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Department of Health, Healthy Living and Seniors
Winnipeg Regional Health Authority
Southern Health-Santé Sud

Manitoba Home Care Program

July 2015

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OFFICE OF THE
AUDITOR GENERAL
MANITOBA

July 2015

The Honourable Daryl Reid
Speaker of the House
Room 244, Legislative Building
450 Broadway
Winnipeg, Manitoba R3C 0V8

Dear Sir:

It is an honour to present my report titled: *Manitoba Home Care Program,* to be laid before
Members of the Legislative Assembly in accordance with the provisions of Sections 14(4) and 28
of *The Auditor General Act*.

Respectfully submitted,

 Original document signed by:
 Norm Ricard

Norm Ricard, CPA, CA
Auditor General

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Auditor General's comments

Many of us have parents, relatives, or friends who benefit from the care and support provided in their homes by the Manitoba Home Care Program. Without this Program many may need to stay longer in hospitals or move more quickly to personal care homes, both of which would be more costly.

The Department of Health, Healthy Living and Seniors provides annual home care funding totaling about $330 million to Manitoba's 5 regional health authorities, who together serve about 24,000 home care clients each month.

The delivery and scheduling of home care services is a logistically complex undertaking. Within any one regional health authority, many services are required by many clients throughout the day and every day. And many clients prefer to be assisted by the same home care workers, day in and day out.

This audit examined how two regional health authorities, Southern Health-Santé Sud and Winnipeg Regional Health Authority, manage and deliver home care services. We focused on these two because together they serve almost 75% of Manitoba home care clients.

We found several opportunities to improve service quality, particularly with respect to the timely preparation and completeness of need assessments and care plans, and regarding the timeliness and reliability of direct services. Left unaddressed, these and other issues discussed in the report may jeopardize the care and welfare of home care clients.

Also of concern is that departmental oversight of the Program was very limited. While the Department has developed home care standards to be followed by all regional health authorities, it does not ensure the authorities are complying with standards and does little to ensure desired service quality and client outcomes are set and achieved. Nor are the quality assurance processes at Southern Health-Santé Sud and Winnipeg Regional Health Authority sufficiently robust to ensure standards, policies and procedures are being consistently met.

Most of the Program's clients are seniors. As Manitoba's senior population is expected to grow rapidly between 2021 and 2036, a corresponding growth in the demand for home care services is likely. This likely increase in demand, in combination with increasingly complex care needs and financial pressures on the entire health care system, presents a significant risk to the future delivery of home care services. While the Department's Blueprint document for continuing care acknowledges a likely increase in demand for home care services, the Department has not forecast this likely demand. This information is needed to understand how best to deal with the challenges of sustaining the Program over the long term.

I would like to thank the officials and dedicated staff at the Department of Health, Healthy Living and Seniors, Southern Health-Santé Sud, and Winnipeg Regional Health Authority for their cooperation and assistance during our audit and acknowledge their significant efforts to properly serve the many clients and families that depend on the services provided by the Program.

I encourage the other regional health authorities to consider the findings and recommendations outlined in this report when assessing the quality of their home care services.

Original document signed by:
Norm Ricard

Norm Ricard, CPA, CA
Auditor General

Winnipeg, Manitoba
July 2015

Main points

What we examined

The Manitoba Home Care Program (the Program) provides healthcare, personal care, and household services to people living at home and needing support—but not necessarily the level of care provided in a hospital or a personal care home. The Department of Health, Healthy Living and Seniors (the Department) funds and oversees the Program. Manitoba's 5 Regional Health Authorities (RHAs) manage and deliver Program services.

We examined the adequacy of the Department's oversight of the Program, including its strategic planning, standards, and monitoring of RHA performance.

We also examined the adequacy of the management and delivery of home care services by Southern Health-Santé Sud and Winnipeg Regional Health Authority (WRHA). This included their processes for identifying people needing home care, assessing client needs and developing care plans, delivering services, and ensuring qualified staff. It also included their quality assurance processes and management information.

While our audit focused mainly on Southern Health-Santé Sud and WRHA, we encourage all RHAs to assess the applicability of our recommendations and act accordingly.

Why it matters

Home care services help elderly people, as well as people with disabilities or chronic health conditions, to live independently at home for as long as safely possible. Without these services, people may need to stay in hospitals or personal care homes, which would be more costly. In 2012/13, an average of 24,514 people received home care services each month and the related annual funding to RHAs totaled $326 million.

The number of Manitobans aged 75 and over is expected to grow rapidly between 2021 (when baby boomers start reaching 75) and 2036. As most home care users are seniors, this population growth is likely to significantly increase the demand for home care services. Ensuring well-planned, sustainable, high-quality home care is therefore critical.

What we found

The Department's oversight was limited

Strategic planning and direction

- In 2014, the Department issued a strategic document, Advancing Continuing Care: A Blueprint to Support System Change. This document sets out the strategic direction for the Manitoba Home Care Program.

- The Blueprint noted that the expected growth in Manitoba's senior population over the next several years would significantly increase the demand for home care services. But the Department had not forecast this demand. This is needed so that, within the context of its planning for the healthcare system as a whole, the Department can plan for the challenges of sustaining the Program over the long term.

- Although the Department described the Home Care Program as "comprehensive, province-wide, [and] universal", it did not specify which direct services, if any, the RHAs were required to offer. We noted housekeeping, laundry, and safety check services were not consistently available in all regions. Instead, the availability of these services depended on where the clients lived.

Home care standards

- The Department set standards for RHAs to follow in delivering home care services, but it did not monitor RHA compliance with its standards, or make the standards publicly available.

Monitoring and publicly reporting RHA performance

- The Department collected and publicly reported statistics on RHA home care service volumes. But it did not regularly review or analyze this information and there were problems with the completeness, accuracy and usefulness of the data. It did not typically collect, monitor, or publicly report information on service timeliness, service reliability, or client outcomes.

Southern Health-Santé Sud and WRHA had gaps in their management and delivery of services

Identifying people who might need home care services

- Both RHAs had processes in place to identify hospital patients needing post-discharge home care services. However, their promotional activities to foster awareness of Program services among doctors and the public, which would help identify people at home needing services, were limited.

Client assessments and care plans

- Client assessments were not always done, complete, or timely in the files we reviewed. When done, 73% of in-home client assessments were completed within 10 working days of assignment to a case coordinator (88% in Southern Health-Santé Sud, 58% in WRHA). Where this standard was not met, assessments were done an average of 36 days after assignment.

- The client assessment tool the Department wanted to implement province-wide was only in place in WRHA. This limited the Department's ability to compile province-wide data.

- Department policy required home care services to supplement—not replace—available family, community, and third-party resources. But determining available family resources was more a matter of negotiation than assessment. And there was no departmental guidance on what was to be considered an "available community resource". This can lead to inconsistent treatment of clients in otherwise similar circumstances, as found in our review.

- The client care plans reviewed sometimes did not address all of the clients' home care needs or were inconsistent with their assessed needs. And planned services did not always meet eligibility, frequency, or duration guidelines.

- Client needs were reassessed within one year of initial assessment, as Department policy required, in only 22% of files reviewed.

Service delivery

- Service start-ups and adjustments were not always prompt, particularly start-ups for clients whose needs were first identified in the community (as opposed to in hospital). Our file review found that, while nursing services began promptly following referral to the Program, personal care and household services took an average of 31 days to start in Southern Health-Santé Sud and 37 days in WRHA.

- Service was not always reliable. Both regions sometimes had to cancel visits, most frequently because they were unable to find available workers at the times they were needed. Clients were therefore required to have back-up plans. In the files reviewed, cancellations were less than 1% of all visits scheduled over a 3-month period—but this still resulted in significant use of back-up plans. During the 3-month period, clients in 38% of the files reviewed were required to use their back-up plans at least once and on average 3.7 times. Individual use of back-up plans ranged from 1 to 13 times.

- Scheduling challenges made it difficult for both RHAs to provide a consistent set of workers for each client. This can be problematic because it can take time for each new worker to become familiar with a particular client's home, medical condition, and care needs.

- The time allotted for staff to perform home care tasks was not always reasonable. And standard time allotments for common home care tasks varied significantly by region. We also found several cases where workers were scheduled to visit 2 different clients in the same time slot and the sum of all scheduled task times exceeded the shift's length.

- Both RHAs encountered difficulties implementing a province-wide staffing initiative (negotiated between the union and all RHAs) that offered some home care workers guaranteed hours and set schedules. The 2 regions were unable to fully schedule all workers' guaranteed hours because the set schedules could not always be easily matched to client assignments. As a result, they had to provide staff wages for the unmatched hours. We estimated that, over a

- 1-year period, the 2 regions could have paid wages totaling over $4 million ($3.7 million in WRHA, $0.3 million in Southern Health-Santé Sud) for these unmatched hours, while at the same time cancelling an estimated 16,400 visits because no staff were available when needed.

- Neither RHA was documenting the receipt, investigation, and resolution of all complaints made to case coordinators about service delivery. Nor were they centrally tracking this information for management review.

- There were inconsistencies in how the 2 RHAs defined and managed nurse-delegated tasks (tasks normally performed by nurses, but sometimes delegated to home care attendants or home support workers). This affected the level of staff supervision, resources required, and timeliness of service start-ups.

Staff qualifications

- Our file review found that most staff met the RHAs' education requirements, but there were gaps in staff training and security checks, and in managing conflict-of-interest declarations.

Quality assurance processes and management information

- Southern Health-Santé Sud and WRHA supervisors conducted few file reviews or home visits to monitor staff performance.

- Both RHAs tracked a variety of management information, including staff time, workloads, and service volume statistics. But they lacked sufficient information on service timeliness, service reliability, and client outcomes.

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Background

Responsibility for the Program

The mission of the Department of Health, Healthy Living and Seniors (the Department) is "to meet the health needs of individuals, families, and their communities by leading [and providing strategic direction to] a sustainable, publicly-administered health system that promotes well-being and provides the right care, in the right place, at the right time". Within this context, the Department funds and oversees the Manitoba Home Care Program (the Program). Manitoba's 5 Regional Health Authorities (RHAs) manage and deliver Program services.

Effective May 30, 2012, the Province amalgamated Manitoba's 11 RHAs into 5 RHAs. The merger of their systems, including home care services, was still ongoing during our audit.

Program description

The mission of the Manitoba Home Care Program is to provide effective, reliable, and responsive home care services that support independent living in the community. The Program provides healthcare, personal care, and household services to people living at home who need support—but not necessarily the level of care provided in a hospital or a personal care home. There are no age restrictions on who can access home care services (although most people served by the Program are seniors) and services are provided free-of-charge.

Program legislation

No provincial legislation specifically governs the Manitoba Home Care Program. It was established through a provincial Order-in-Council in 1974.

RHAs deliver home care services under the authority of *The Regional Health Authorities Act.* This Act lists home care services as one of the 13 health services Manitoba RHAs must deliver and administer.

The Canada Health Act specifies the conditions and criteria the provincial and territorial governments must meet to receive federal funding for health care. Under this Act, home care is an "extended health service," not an "insured service". This means that home care services are not guaranteed under this Act, unlike hospital services.

The Health Services Insurance Act establishes the Manitoba Health Appeal Board. The Manitoba Health Appeal Board Regulation under this Act specifies the right for a person dissatisfied with an RHA decision related to the Program to appeal to the Board. In 2012/13, the Board received 5 appeals of RHA decisions about home care services.

Funding, staffing, and service volumes

In 2012/13, the Department provided about $326 million in home care funding to RHAs. As **Figure 1** shows, $251 million or 77% of this went to Winnipeg Regional Health Authority (WRHA) and Southern Health-Santé Sud.

Figure 1: WRHA and Southern Health-Santé Sud received 77% of Home Care funding in 2012/13
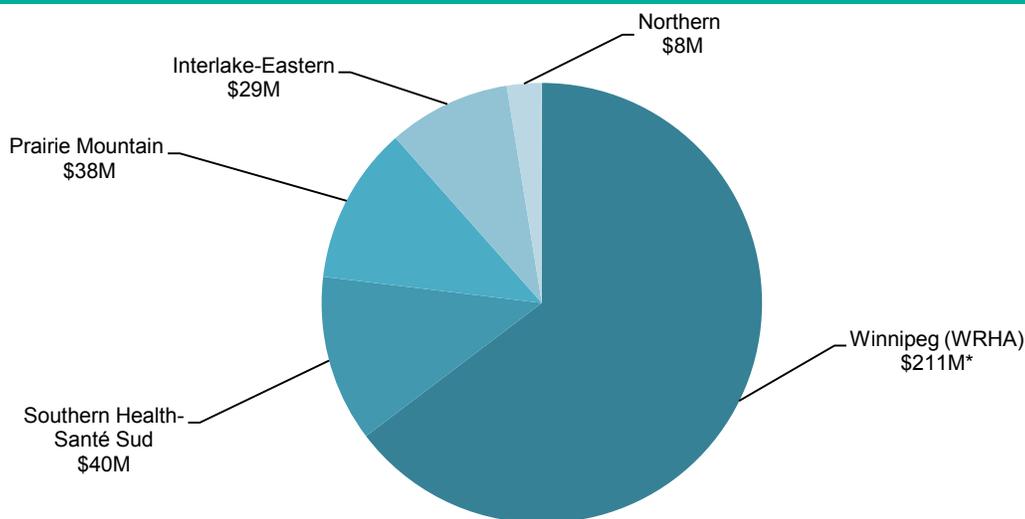
* This includes $9M for specialized home care services (such as home nutrition) administered by the WRHA on behalf of all RHAs.

Source: The Department of Heal h, Healthy Living and Seniors

The Department provides annual funding to RHAs based on historical funding for regularly recurring operations, with adjustments for wage settlements and approved special initiatives. The Province's annual estimates show a specific amount allocated to RHAs for home care services, but in practice the Department and RHAs operate under a "global funding" model that allows RHAs to allocate and transfer funds between program areas (such as home care and acute care) as they see fit. Under this model, the Department provided funding ranging from $10,534 per home care user in the Northern region to $14,342 in the Winnipeg region for 2012/13.

Most home care funding is for staff salaries. At the time of our audit, WRHA had about 3,150 home care employees, and Southern Health-Santé Sud had about 800. Most employees were home care attendants, home support workers, nurses, case coordinators, or resource coordinators.

Typical duties of home care staff are as follows:

- **Home care attendants** provide personal care assistance (such as help with dressing, grooming, and bathing), respite services to relieve clients' caregivers, medication assistance, and delegated nursing tasks (such as administering eye drops).
- **Home support workers** (employed in WRHA, but not Southern Health-Santé Sud) provide household assistance (such as help with housekeeping and preparing meals), medication assistance, and respite services.

- **Nurses** provide health care services (such as wound care, monitoring of clients' chronic conditions, and health education and counselling) and supervise any nursing tasks delegated to home care attendants.
- **Case coordinators** assess clients' needs, develop care plans, and provide on-going case management services.
- **Resource coordinators** supervise and schedule home care attendants and home support workers.

Between 2007/08 and 2012/13, overall home care funding grew from $252 to $326 million, a 29% increase. Salaries and benefits paid by RHAs also increased by 29%, while the average number of home care users per month grew by 7%, from 22,986 to 24,514. WRHA served about 60% of these users; Southern Health-Santé Sud served about 14%.

At the time of our audit, most of the Department's oversight of the Home Care Program was done by the executive director of Continuing Care and one full-time staff member.

Factors affecting the demand for home care services

Research literature identifies many factors driving current and future increases in the demand for home care services, including:

- increases in the senior population.
- more individuals living with chronic health conditions.
- the desire to live independently for as long as safely possible.
- fewer adult children available to care for their aging parents—the result of smaller families, increasing childlessness, and greater family mobility.
- efforts to use health care resources more cost-effectively by discharging patients from hospital as soon as safely possible and delaying admission to personal care homes for as long as possible.

Private home care agencies

A number of private home care agencies operate in Manitoba, alongside the public Program. As an alternative or supplement to the public Program, people may pay these private agencies to supply the services of health care aides, home support workers, and nurses. Private agencies also provide some services the Program does not offer, such as companionship, shopping, and transportation. In addition, RHAs may use private home care agencies to supplement their own staff.

Audit approach

We examined the adequacy of the Department's oversight of the Manitoba Home Care Program, including its strategic planning, standards, and monitoring of RHA performance.

We also examined the adequacy of Southern Health-Santé Sud's and WRHA's management and delivery of regional home care services. This included their processes for identifying people needing home care, assessing client needs and developing care plans, delivering services, and ensuring qualified staff. It also included their quality assurance processes and management information.

We chose to focus on Southern Health-Santé Sud and WRHA because in 2012/13 they served 74% of the roughly 24,000 Manitoba clients receiving home care services each month. They also received 77% of the $326 million in home care funding that the Department provided to RHAs. WRHA served about 14,683 clients monthly, with funding of $211 million; Southern Health-Santé Sud served about 3,312 clients monthly, with funding of $40 million.

We conducted most of the audit between May 2013 and June 2014. We primarily examined processes in place between February 2012 and January 2014. Our audit was performed in accordance with the value-for-money auditing standards established by the Chartered Professional Accountants of Canada (formerly the Canadian Institute of Chartered Accountants) and, accordingly, included such tests and other procedures as we considered necessary in the circumstances.

The audit included review and analysis of legislation, policies and practices, information systems, records, reports, minutes, correspondence, and Southern Health-Santé Sud and WRHA files. We also interviewed staff from the Department, Southern Health-Santé Sud, and WRHA, as well as various home care stakeholders. We examined limited information from the other 3 RHAs, including the reports they sent to the Department and the results from a survey we sent to all RHAs.

Our audit excluded any home care services that were specialized sub-programs within the broader Home Care Program (such as home oxygen and palliative care services). In 2012/13, these sub-programs accounted for about 20% of the Program's total cost.

Findings and recommendations

1.   The Department's oversight was limited

The Department's website describes the Manitoba Home Care program as the oldest comprehensive, province-wide, universal home care program in Canada and lists the Department's responsibilities for the Manitoba Home Care Program, which include:

- strategic planning for priority populations.
- home care policy development and interpretation.
- monitoring and analysis of Program activity and its impact on the target population and the health care delivery system.
- development and monitoring of standards and provincial outcomes.
- research on, and development of, program benchmarks and best practices.

1.1   Strategic planning and direction

1.1.1   The Department set a strategic direction

The Department set the strategic direction for the Manitoba Home Care Program through its plans for "successful aging" and continuing care. This approach recognized that most home care clients were 65 or older. It also reflected the Department's view that home care services were part of a continuum of care providing both community and institutional services to people with both short- and long-term support needs.

The Department's 2006 *Long Term Care Strategy* set out a plan to:

- provide home care services to help seniors stay in their homes for as long as safely possible.
- ensure an adequate supply of beds in personal care homes when needed.
- develop various community-based supports (such as supportive housing) to provide a bridge between home care services and personal care homes.

In 2014, the Department issued a new strategic document, *Advancing Continuing Care: A Blueprint to Support System Change*. Management said it created the Blueprint after consulting RHAs and various other stakeholders (including other government departments, private agencies, community groups, and health care providers). Proposed Home Care Program changes in the Blueprint included:

- making greater use of home visits by medical professionals (noting that hospital home teams were already being pilot-tested in selected areas).
- developing a "restorative model of home care" that would put a greater focus on teaching clients self-care and coping skills, with the goal of having them perform tasks more independently (potentially including a range of services, such as home stroke rehabilitation, home safety assessments, adaptation recommendations, and fall prevention).
- enhancing the role of home care case coordinators to help clients better navigate the health care system.
- developing technology-assisted home care.

- providing additional support for home care travel in rural and northern areas.
- reviewing and enhancing home care respite services for caregivers.
- developing a human resources strategy to meet the anticipated volume and complexity of clients' home care needs.

At the time of our audit, the Department had a proposed general timeline for Blueprint "action areas". This could be further developed with a specific timeline, implementation plan, measurable performance goals, and an estimate of the incremental funding required for each planned initiative.

1.1.2 No planning to address the forecast growth in senior population

The Department's Advancing Continuing Care Blueprint noted that while only about 14% of Manitobans were aged 65 or older in 2010, this was expected to roughly double by 2036—significantly increasing the demand for home care services. However, the Department had not forecast this increased demand.

The Blueprint also noted the links between home, hospital, and personal care home services. Home care services can help clients return sooner to their homes or remain longer in their homes, rather than using higher intensity and more costly institutional services. This helps reduce the pressures on hospitals and personal care homes—but may increase the pressure on the home care system.

The Blueprint did not specifically consider how the home care system would deal with these challenges and manage the sustainability of home care services. The Blueprint stated, "we must re-examine how we fund health care", but had no further details or proposed actions related to funding or program sustainability.

> **Recommendation 1:** We recommend that the Department forecast the increased demand for home care services likely to result from the expected growth in the senior population so that, within the context of its planning for the healthcare system as a whole, it can understand the staff and financial resources needed to sustain Program services over the long term.

1.1.3 Regional service variations allowed within a "province-wide, universal" program

A publicly available guide developed by the Department describes the various services the Program offers. However, we found instances where services described in the guide were not offered in all regions, even though the Department's website describes the Home Care Program as "comprehensive, province-wide, [and] universal".

We found that light housekeeping (other than clean-up after performing other home care tasks) was only offered by 2 of the 5 regions, including WRHA. Laundry services (other than that related to incontinence), was only offered by 2 of the 5 regions. As of July 31, 2013, WRHA records showed that 5,915 WRHA clients were receiving light housekeeping and laundry services

at an estimated annual cost of almost $12 million. In contrast, Southern Health-Santé Sud did not provide similar services.

We found similar variation in services not listed in the Program guide. Safety-check visits were only offered in 2 of the 5 regions, including Southern Health-Santé Sud, but not WRHA.

Department officials offered two reasons for these regional variations. First, the Province does not guarantee home care services because *The Canada Health Act* recognizes home care as an "extended health service", not an "insured service". Second, RHAs have the flexibility to deliver services based on their population needs (as determined by their community health needs assessments) and the global funding the Department supplies (which can be reallocated between programs).

The Regional Health Authorities Act requires RHAs to provide home care services, but does not specify the types of home care services required. However, section 3(3) of the Act gives the Minister the authority to give directions to RHAs to:

- achieve provincial objectives and priorities.
- provide guidelines for the RHAs to follow in carrying out and exercising their responsibilities, duties, and powers.
- coordinate the work of the RHAs and government.

The Department's *Core Health Services* document states that regions' home care services must include assessment, care planning/coordination, and direct services—but it does not specify the types of direct services required.

As a result, some of the direct services offered to home care clients with similar needs in similar circumstances depend on where the clients live. In our view, this contradicts the claim on the Department's website that the Home Care Program is "comprehensive, province-wide, [and] universal" and may be confusing to the public.

> **Recommendation 2:** We recommend that the Department:
> a. specify which direct services (if any) RHAs must make available to home care clients, no matter where they live.
> b. make it clear in all their published materials describing home care services which services RHAs must provide (if any) and which are optional.

1.2   Home care standards

1.2.1   Departmental standards in place, but not publicly available

The Department set standards for RHAs to follow in delivering home care services. These were documented in its *Manitoba Home Care Administrative Manual*. The Manual had standards, policies, and guidelines covering eligibility for services, assessment of client needs, and service delivery. We compared the Department's home care standards and policies to those of 7 other provinces: British Columbia, Alberta, Saskatchewan, Ontario, New Brunswick, Nova Scotia, and Newfoundland and Labrador.

We found that 2 provinces (Alberta and Ontario) have legislated standards. The remaining 5 make their standards and policies publicly available. Manitoba's standards for home care services are not legislated. Nor are they publicly available, which decreases accountability and transparency.

While the Department's key home care standards and policies were generally consistent with those in the other provinces, it did not have a policy for dealing with suspected client abuse or neglect—although the other 7 provinces we reviewed did. Manitoba did have a provincial strategy to prevent elder abuse and it funded an external agency to provide related confidential intervention and protection services. To be consistent with the 7 other provinces, the Department may want to consider developing its own policy and linking it to the provincial strategy.

A significant policy in place in Manitoba—but not in any of the other provinces we examined—required all home care clients to have back-up care plans, whenever possible, to use during service interruptions. **Section 2.3.2** discusses these plans more fully.

> **Recommendation 3:** We recommend that the Department make its home care standards and policies public, as done in other provinces.

1.2.2 No monitoring of RHA compliance with Department standards

The Department consulted with RHAs in developing its standards and policies, and then formally communicated them to RHAs by distributing its Administrative Manual. It also gave RHA representatives further explanations of standards and policies as needed. But it did not monitor RHAs' compliance with its standards and policies. Compliance monitoring helps ensure that standards and policies are followed and that planned service quality is achieved. Without monitoring, the level of compliance is likely reduced.

We found examples of other jurisdictions that monitored compliance with standards. Nova Scotia's home care manual indicated there were auditing processes to assess compliance with established policies and standards. Also, when other jurisdictions out-sourced home care services to for-profit or not-for-profit service providers, they typically monitored the service providers to ensure they met performance standards. And in the UK, the Care Quality Commission checked whether home care agencies were meeting government standards and publicly disclosed the inspection results, both for all service providers and for each individual provider.

Various methods could be used to monitor compliance with key standards. Departmental staff could periodically review RHA activity. Or RHAs could review their own compliance with the Department's standards as part of their quality assurance processes (described in **section 2.5**), and then report the results to the Department. The former provides more independent assurance. The latter reflects RHAs' responsibility for establishing quality assurance programs (as described in section 23(2)(k) of *The Regional Health Authorities Act*) and could be periodically verified by the Department without incurring significant incremental costs.

The Regional Health Authorities Act requires RHAs to be accredited and accreditation reports to be submitted to the Minister. Where the accreditation standards related to home care are similar to the Department's standards and policies, the Department may be able to place some reliance on the RHA accreditation reports periodically prepared by Accreditation Canada.

Recommendation 4: We recommend that the Department identify key provincial home care standards and require RHAs to review their compliance with these standards and report the results to the Department.

1.3 Monitoring and publicly reporting RHA performance

1.3.1 Problems with service volume statistics; financial monitoring improving

The Department is responsible for monitoring and analyzing Program activity, and evaluating the impact of the Program on the target population and the health care delivery system. To this end, it required all RHAs to submit both monthly statistics reports and monthly financial reports.

The monthly statistics reports had a variety of service volume information, including the:

- average number of clients served, by gender and age range.
- number of admissions to the Program, by referral source, gender, and age.
- number of clients with particular characteristics, such as dementia.
- number of clients receiving selected services.

The Department did not review the statistics reports, except on an ad hoc basis; nor did it analyze the data. We noted reports missing significant amounts of information, which resulted in under-stated totals in the annual provincial statistics compiled and publicly reported by the Department. And some data appeared unreasonable. For example, WRHA reported far fewer clients with dementia (less than 1%) than another RHA with a much smaller population. These problems undermined the usefulness of the reports, particularly for analyzing trends over time.

Department officials said some RHAs found it hard to track the required statistical data with their existing tools and systems. At the time of our audit, some RHAs had only recently implemented an information system that tracked the home care services being delivered.

Reporting on the "number of clients receiving services by category" tracked the number of clients receiving services from the different types of home care workers (for example, nurses, home care attendants, and home support workers). Actual services provided (such as assisting clients with medication or providing respite services for clients' caregivers) were not tracked. The latter would be more meaningful. Also, reporting on the different types of referral sources for admissions included "doctor" and "hospital" categories, but staff in some regions used either category for referrals from hospital doctors, effectively reducing the usefulness of this information.

All RHAs were required to submit monthly financial reports comparing the funding from the Department and the annual budget approved by the RHA board to the actual and forecast expenditures for each program area, including home care. Although several monthly reports from periods prior to the fall of 2013 had not been submitted, Department officials expected this to improve when RHAs began reporting on an amalgamated basis.

The Department performed a high-level review of the financial reports it received. Initially, this examined and explained only changes in the total projected provincial surplus or deficit for all

RHAs. During our audit, the process changed to include a review of each RHA's projected surplus or deficit, by program area.

The Department did not try to link the financial and statistical reports to see if together they presented a consistent understanding of RHA activities. With complete and accurate information, the Department could use the 2 reports to identify and explain variances from expected results, anomalies (such as differences between regions), and longer-term trends.

> **Recommendation 5:** We recommend that the Department:
>
> a. review the monthly home care statistics it requires from RHAs to ensure the statistics will provide all key information needed to effectively monitor and analyze Manitoba Home Care Program performance.
> b. monitor all key home care information it receives for completeness and reasonableness, particularly information being publicly disclosed in its annual statistics report.
> c. analyze RHAs' statistical reports, in conjunction with their financial reports, to identify and follow-up variances from expected results, anomalies, and longer-term trends for the Manitoba Home Care Program.

1.3.2   Minimal monitoring of service quality and client outcomes

At the time of our audit, the Department was developing a performance management framework and a related management information system. The draft framework document stated that all the Department's branches (including the Continuing Care Branch, which housed the Home Care Program) would be responsible for developing and monitoring performance indicators and targets related to their mandates.

While the Department required RHAs to submit service volume information on home care services (as **section 1.3.1** describes), it received limited information about the quality of home care services or home care client outcomes. Both would improve its monitoring of RHA performance.

Our review of Southern Health-Santé Sud and WRHA files found problems with both the timeliness and reliability of home care services. **Sections 2.3.1 and 2.3.2** describe these further. The RHAs generally did not track or monitor their performance in these areas. Ideally, RHAs would measure service timeliness by tracking the time from referral to the Home Care Program (or discharge from the hospital) to first delivery of service in the home. And they would measure service reliability by tracking the number of times clients needed to use back-up plans. While this data was often available in RHAs' information systems, not all of it could be easily extracted. In addition, the date of referral to the Program was often not recorded or recorded inaccurately.

Some RHAs conducted regular or intermittent client satisfaction surveys. Southern Health-Santé Sud and WRHA surveys asked some questions about service quality, but they typically did not ask specific questions about service timeliness or reliability. And RHAs did not share survey results with the Department.

Web Version

The Department required RHAs to monitor and report all critical incidents and critical occurrences (those events and circumstances resulting in serious or undesirable outcomes), including those related to their home care programs. But RHAs generally did not monitor other types of outcomes, such as clients' functional improvements, falls, pressure ulcers, emergency room visits, or admissions to hospital.

Some jurisdictions gathered more information on service quality and client outcomes. The U.S. government tracked a large number of service quality and client outcome measures for "Medicare-certified" home health agencies on its Home Health Compare website. And the home care client information reported by Ontario Community Care Access Centres (CCACs) to Health Quality Ontario included the following measures:

- number of days within which 90% of those referred from an inpatient hospital setting received their first home care service visit after discharge.
- number of days within which 90% of those referred from a community setting received their first home care service visit after application.
- percentage of clients with (i) unplanned emergency department visits and (ii) hospital readmissions, within 30 days of acute hospital discharge.
- percentage of clients with a fall in the last 90 days.
- percentage of clients with a new pressure ulcer.
- percentage of clients without influenza vaccinations in the past 2 years.
- percentage of clients satisfied overall with service providers and care coordinators.
- percentage of clients placed in long-term care who could have stayed home or somewhere else in the community.

> **Recommendation 6:** We recommend that the Department, in consultation with RHAs, define and monitor performance measures for service timeliness, service reliability, and key client outcomes for the Manitoba Home Care Program.

1.3.3 Public performance reporting needs improvement

The Department's annual report disclosed the total funding provided to RHAs for home care. The Department also regularly reported selected home care statistics in its annual statistics report. Both these reports were publicly available on its website. But as **section 1.3.1** explains, some home care statistics were inaccurate.

All RHA annual reports disclosed the amounts actually spent on home care services. RHAs also posted reports from Accreditation Canada on their websites. As **section 1.2.2** notes, Accreditation Canada periodically reviews various RHA services, including home care services, to see if they meet Accreditation Canada's standards.

Some jurisdictions publicly reported more information on the performance of their home care programs. For example, all information reported by Ontario CCACs to Health Quality Ontario (described in **section 1.3.2**) was publicly available, both the provincial results and the results for each CCAC. And each health authority in British Columbia publicly reported on "the percent of

people aged 75+ receiving home health care and support", adding perspective to the numbers being served.

> **Recommendation 7:** We recommend that the Department work with RHAs to expand and improve public performance reporting on the Manitoba Home Care Program.

2. Southern Health-Santé Sud and WRHA had gaps in their management and delivery of services

In Southern Health-Santé Sud, community-based case coordinators manage all home-care client files. In WRHA, hospital-based case coordinators arrange for services to meet clients' more immediate needs after discharge from hospital; community-based nurses manage the files if the clients require only nursing services; and community-based case coordinators manage all other files.

For each region, we examined 40 home-care client files managed by community-based case coordinators. In WRHA, we also reviewed 25 files managed by nurses and 25 managed by hospital-based case coordinators. We selected the client files randomly, focusing on more complex files (those where clients had higher-risk ratings or were receiving several hours of service weekly).

2.1 Identifying people who might need home care services

2.1.1 Processes in place to identify hospital patients needing services

Both regions had processes to identify hospital patients requiring post-discharge home care services. These processes depended on both hospital and home care staff.

In WRHA, hospital-based case coordinators identified people who needed post-discharge home care services. They did this by attending hospital rounds and responding to consult requests from hospital staff, families, or patients. They also developed short-term care plans to meet clients' more immediate needs on discharge. And they referred client files to the appropriate community office for scheduling services and post-discharge case management.

In Southern Health-Santé Sud, some case coordinators were located in hospitals, but they coordinated services for home care clients referred from both the hospital and the community. They identified people needing post-discharge services the same way WRHA hospital-based case coordinators did. Case coordinators not based in their area's hospital still attended hospital rounds and responded to referrals from hospital staff.

These processes were not infallible. Our file review found a small percentage of clients with post-discharge home care needs who were not identified until they returned home or were readmitted to hospital.

Web Version

2.1.2 Limited Program promotion to help identify people at home needing services

The Program relies on self-referrals and referrals from community doctors, family members, and friends to identify people living at home who might require home care services. Therefore, RHAs need to foster awareness of the Program with both community doctors and the public.

In contrast, Denmark legislation requires all people over 75 to be offered annual or more frequent home visits to assess their need for services. This helps put home care services in place before the lack of these services leads to emergency room visits or hospital admissions.

We found that the Department and WRHA websites provided information for the public on both Program eligibility and the different types of home care services available. They also provided phone numbers for additional information. The Department's website (which provided both a Manitoba Home Care Program guide and a Seniors' Guide with Home Care Program information) was the most detailed. It had information on assessment and care planning; appeals; roles and responsibilities of clients, their families, and home care staff; and related government programs, such as those offering supportive housing and caregiver tax credits. RHAs' websites could benefit from a link to the Department's website for more detailed Program information.

WRHA also made Program presentations to stakeholders (such as the Alzheimer Society of Manitoba), and promoted the Program at expositions (such as the Age and Opportunity Seniors Housing and Lifestyles Expo). And Southern Health-Santé Sud distributed Home Care Program pamphlets to some self-owned facilities, but not to community doctors' offices. WRHA had not developed any home care pamphlets for distribution.

We visited or called 20 community doctor offices in the 2 regions: 6 of them had pamphlets from private home care agencies, but none had information (such as posters or pamphlets) on Manitoba's publicly-funded Home Care Program. In addition, staff in both regions told us that doctors' knowledge of the details of home care services could be enhanced.

> **Recommendation 8:** We recommend that Southern Health-Santé Sud and WRHA work with the Department to strategically promote greater awareness of Manitoba Home Care Program services to doctors and the public.

2.2 Client assessments and care plans

Case coordinators assess prospective clients' needs and their eligibility for Program services, and then develop care plans listing the services to be provided. Generally, assessments to meet clients' long-term needs are completed in their homes. Assessments and care plans developed while clients are in the hospital focus more on ensuring that adequate supports are in place to ensure clients' safety until in-home assessments can be done.

2.2.1 At-home client needs assessments not always done, complete or timely

Both regions had standards for the timeliness of at-home client needs assessments. WRHA required its community case coordinators to conduct them within 10 working days of assignment.

Southern Health-Santé Sud required its case coordinators to conduct them within 10 working days of a client's referral to the Program. But neither region measured whether they met these standards.

In Southern Health-Santé Sud, assignments to case coordinators were often simultaneous with intake of the referral because case coordinators frequently handled intakes themselves. However, in 3 offices, an intake coordinator received referrals and then distributed them to case coordinators. There was no documentation tracking the time from intake to assignment to a case coordinator, but staff said referrals were generally assigned the same or next day.

In WRHA, it generally took more time for referrals to be assigned to case coordinators—particularly in community offices that assigned non-urgent referrals to case coordinators weekly, rather than daily. This increased the time clients waited to be contacted and assessed. Typically, staff at a central intake unit received community referrals and then forwarded them to the appropriate community office the same or next day. Supervisors then assigned referrals from both central intake and hospital-based case coordinators to the community case coordinators.

Our file review found that WRHA referrals flagged as urgent were usually assigned to case coordinators within 2 days, but not all urgent referrals were properly flagged by central intake staff. Under WRHA guidelines, urgent situations included those with a caregiver in crisis, display of risky behaviours, or an immediate risk of hospitalization. In the files we reviewed, non-urgent referrals were assigned to case coordinators within an overall average of 4 days.

Community case coordinators completed client needs assessments in all but 3 files we reviewed. In files with completed assessments, 73% were done within 10 working days of assignment to a community case coordinator (88% in Southern Health-Santé Sud, 58% in WRHA). The other 27% were done an average of 36 days after assignment. About 37% of these late assessments were for clients waiting for their longer-term needs to be assessed, but already receiving some services through short-term care plans. The rest of the delayed assessments occurred, on average, 26 days after assignment and resulted in service start-up delays. Only one assessment was scheduled later to accommodate client wishes. And one WRHA assignment flagged as urgent was not assessed on an expedited basis.

In WRHA, some overlap existed between the assessments done by community case coordinators and the detailed information central intake staff gathered to triage referrals. This duplication seemed inefficient.

Overall, 77% of assessments were fully completed (58% in Southern Health-Santé Sud, 95% in WRHA). Incomplete Southern Health-Santé Sud assessments were typically missing some of the required information on psychosocial function, personal care, or daily living activities. Incomplete WRHA assessments were missing almost all required information.

WRHA did not require its standard client needs assessment tool to be used for "nursing-services only" files—it only required a nursing assessment. Nursing assessments could identify a need for more nursing services—but not any non-nursing services. In the files we reviewed, WRHA nursing assessments were fully completed 61% of the time.

Recommendation 9: We recommend that Southern Health-Santé Sud and WRHA develop plans to improve the timeliness of at-home client needs assessments and monitor progress in meeting their timeliness standards.

Recommendation 10: We recommend that WRHA review its central intake processes to ensure staff flag all urgent referrals and avoid unnecessarily duplicating the needs assessments done by case coordinators.

Recommendation 11: We recommend that Southern Health-Santé Sud and WRHA investigate why required client needs assessments are not always done or fully completed, and remedy this.

2.2.2 Problems assessing family, community, and third-party resources available

Case coordinators assessed each client's general eligibility for the Program, and their eligibility for specific services. General eligibility required Manitoba residency and registration with the Department. Staff properly assessed and supported decisions on general eligibility in all but one file we examined.

To assess eligibility for specific services, case coordinators first assessed each client's specific needs. Then they assessed the family, community, and third-party resources available to meet those needs. This second step was required because the Department policy stated home care services were intended to supplement—not replace—these available resources.

Determining the availability of family resources was challenging. The policy required case coordinators to consider "those activities which others in the household, or which family/friends living within a reasonable distance, are performing, or realistically could perform". However, regional home care staff said that often determining this was a matter of negotiation, not assessment.

Negotiation can lead to inconsistent and therefore unequal treatment. Some family members may agree to provide more support than others and some case coordinators may be more assertive than others. For example, we found two clients received meal preparation assistance, even though family members living in the same household or building "realistically could" have provided this help. In contrast, another client was told that a family member had to help with all transfer assistance required (for example, from bed to chair), even though this interfered with the family member's job. Neither region gave its case coordinators any specific training on negotiation.

Determining the availability of community resources was equally challenging because there was no definition of "available community resources". It was unclear if staff should consider only free and low cost resources, or also consider a client's ability to afford more costly resources. In practice, case coordinators generally considered private housekeeping services and Meals on Wheels (a not-for-profit agency supplying meals for a fee to those requiring meal assistance) to be

community resources, but not private home care agencies. Some case coordinators told us they asked clients if they could afford certain community services, but there was no income testing required to objectively assess a client's ability to afford fee-based services.

People otherwise eligible for home care services might also be eligible for similar services offered by third-party providers, such as Veterans Affairs Canada, the Workers Compensation Board of Manitoba, Manitoba Public Insurance, and the provincial Department of Family Services. In some cases, these parties directly provide all or some of the care clients might require; in others, they reimburse RHAs for certain costs. WRHA had a formal agreement with only one third-party provider that set out the coordination of services and recoverable costs; Southern Health-Santé Sud had none. Neither region had a comprehensive list of all potential third-party providers on their assessment forms.

We selected a separate sample of 20 files (10 in each region) where referral to the Program did not result in admission to see if the files were properly handled. Seventeen files legitimately explained the reason for non-admission (typically the client did not need or want services, despite having been referred), but 3 did not. One file noted that the referred person was eligible for personal care services, but that a family member's schedule would make service coordination difficult. Another stated that care would be provided by others, without any supporting documentation or assessment of the client's needs. And another lacked any supporting rationale.

> **Recommendation 12:** We recommend that Southern Health-Santé Sud and WRHA ensure that case coordinators have the training and tools to:
>
> a. assess and negotiate, as consistently as possible in similar circumstances, the support that family members can realistically be expected to provide for home care clients.
> b. identify all possible third-party providers so coordination of home care services and cost recoveries can be arranged and properly documented.
> c. adequately support and document the reasons for Program non-admissions.

> **Recommendation 13:** We recommend that Southern Health-Santé Sud and WRHA work with the Department to:
>
> a. clearly define "available community resources" and clarify if client ability to pay is relevant when assessing the availability of a community resource.
> b. develop processes to verify client ability to pay if it is relevant in assessing the availability of a community resource.

2.2.3 Department's preferred assessment tool not implemented in all regions

One goal stated in the *Manitoba Home Care Program Administrative Manual* was to consistently and comprehensively assess all people referred to the Program with a standardized screening and assessment tool approved by the Department. But only the WRHA had the Department's tool of choice, a resident assessment instrument known as interRAI Home Care (RAI-HC). RAI-HC is internationally acknowledged as the best computer-based system to assess and document the profiles and needs of home care clients and provide information for program planning.

Some Winnipeg hospital departments also had access to RAI-HC and used the information to help identify and treat home care clients admitted to hospital—although it was not available in the emergency rooms of the 2 largest hospitals.

All other RHAs (including Southern Health-Santé Sud) had not yet implemented this tool. Department officials told us that implementing RAI-HC in the remaining RHAs was a long-term goal, but not an immediate priority. Nova Scotia, Ontario, Saskatchewan, Alberta, British Columbia and the Yukon all used RAI-HC throughout their jurisdictions. Without this tool, the Department's ability to compile province-wide home care data is limited.

> **Recommendation 14:** We recommend that the Department develop a plan for province-wide implementation of the RAI-HC client assessment tool.

2.2.4 Care plans sometimes had gaps and inconsistencies with assessed needs

In the files reviewed, case coordinators typically completed care plans (which listed the home care services to be provided) the same day as assessment, or within the next few days. However, 13 of 80 clients (10 in Southern Health-Santé Sud, 3 in WRHA) had care plans inconsistent in some way with their assessments. In some cases, no services were planned to meet a client's assessed need. In other cases, services were planned for a need not identified on the assessment or otherwise explained in file notes. And 6 care plans (all in Southern Health-Santé Sud) were unclear as to the frequency or amount of some services to be provided (for example, they stated "respite as staffing allows" or "bath once or twice a week").

Case coordinators are expected to discuss care plans with clients and then have them (or their designated representatives) sign paper versions of the plans to show the discussions occurred. These plans also list important Program contact numbers. Only 45% of the files we examined had the carbon copy of the paper care plan on file (the original was for the client), and only 64% of those on file had been signed by the client or their representative. In addition, 30% of the paper care plans differed from the electronic versions used to schedule client care, with no documented reason for the difference.

Department policy requires all home care clients to have back-up plans, if possible. In practice, this was simply the name of a person (usually a family member or friend) to call if the region could not deliver planned services. Our file review found that most files specified a "back-up contact" or listed a "primary contact" who presumably could provide back-up services. But 3 of the listed contacts in WRHA either lived in a different province or were representatives from other social services organizations serving the client—making it doubtful they could be relied on to provide back-up services.

Case coordinators could arrange for care plan services to exceed established protocols (for example, two baths per week might be planned, even though the client was only eligible for one)—but only with supervisory approval. In the files we examined, case coordinators made exceptions to eligibility, frequency or duration protocols without supervisory approval for 16 of 80 clients (14 in Southern Health-Santé Sud, 2 in WRHA).

We also selected a separate sample of 10 care plans (5 from each region) where the weekly service-hours exceeded the 55-hour maximum set by the Department to see if these plans were properly approved. Regional supervisors could approve exceptions to the 55-hour limit for clients living with unique or complex care requirements. Only 3 of 10 plans had the required approval on file, although all appeared to meet the Department's criteria for exceptions. Regional records showed that less than 1% of all clients exceeded the 55-hour-limit at a given time.

Client needs and circumstances change over time, so care plans need to be periodically adjusted. Department guidelines require formal reassessments to be conducted annually or more often, based on the degree of client risk. However, in the files we reviewed:

- 22% of clients (15% in Southern Health-Santé Sud, 28% in WRHA) were reassessed within one year of initial assessment.
- 28% were reassessed 12-18 months after initial assessment.
- 50% of clients were not reassessed within 18 months of initial assessment.

Our file review showed that WRHA clients with high-risk ratings were generally not reassessed more frequently than those with lower-risk ratings. Southern Health-Santé Sud did not risk-rate clients.

There were also ad hoc adjustments to care plans outside the formal reassessment process. These reflected new doctors' orders, as well as concerns raised by clients, their families, and home care staff delivering on-going services. However, 11% of the files we reviewed had no reassessment or ad hoc adjustments to their care plans over the period examined.

> **Recommendation 15:** We recommend that Southern Health-Santé Sud and WRHA ensure that client care plans:
>
> a. meet all clients' assessed needs, and only those needs.
> b. clearly state the frequency or amount of service to be delivered.
> c. specify a reliable back-up plan that can be actioned as required.
> d. are signed by clients or their designates to show they reviewed and discussed them.
> e. are updated at least annually, using a formal reassessment process that prioritizes higher-risk clients.

> **Recommendation 16:** We recommend that Southern Health-Santé Sud and WRHA ensure that file documentation for client care plans includes:
>
> a. supervisory approval when planned services exceed established protocols.
> b. a copy of the paper care plan signed by clients or their designates.

2.3   Service delivery

2.3.1   Service start-ups and adjustments need to be more timely

After assessment of their needs and development of care plans, clients wait while the services in their plans are arranged. Clients whose needs are identified in a hospital wait either in the hospital or in their homes. Doctors sometimes decide patients can be safely discharged from hospital to wait for services at home. Other times, doctors decide that patient safety will be at risk if services are not in place at discharge. To avoid this, patients medically fit to return home are held in hospital until services are arranged.

We examined the timeliness of service start-ups both for clients whose needs were identified in the hospital and in the community. Southern Health-Santé Sud required service to begin within 2-3 days of a service request, but did not monitor if this standard was being met. WRHA had no similar standard.

In WRHA, 13 of 25 home care clients with files managed by hospital-based case coordinators were held in hospital an average of 7 days (15 and 19 days in 2 cases) after doctors declared them medically fit to return home. WRHA prioritized home care services for these "hospital holds" because their beds were needed for other patients. WRHA data showed that between 2008/09 and 2013/14, the average number of days clients were held in hospital waiting for home care services decreased 29%, from 7.3 to 5.2 days. Southern Health-Santé Sud also held patients in hospital under similar circumstances and tracked hospital holds, but not whether they were related to home care. Although "hospital hold" patients were never left without services, their wait times still adversely affected customer service and healthcare system efficiency.

In some cases, patients were discharged with the understanding that family would provide needed support until home care services were in place (including 2 "hospital hold" patients who eventually decided they didn't want to wait in hospital any longer). But case coordinators in both regions told us that, in their view, some patients were being discharged before adequate supports were in place. Our file review found one case where a person needing daily support was discharged without any family or Program support in place.

Our file review also showed that clients not held in hospital until home care services were in place waited an average of 8 days (4 in Southern Health-Santé Sud, 10 in WRHA) for each service to start following discharge. During this time, clients had no hospital or home care support. The following factors contributed to longer wait times for services following hospital stays:

- hospital staff did not always give case coordinators sufficient or any advance notice of the discharge.
- neither region had staff to coordinate or arrange start-up services during evenings and weekends.

Case coordinators can assess clients' needs and prepare care plans before discharge, but they can't request service start-ups until discharge dates are established. Because discharge planning is complex, hospital staff can't always give sufficient or any advance notice of discharge dates. However, opportunities likely exist for more collaborative planning.

Southern Health-Santé Sud and WRHA both had some resource coordinator services available on evenings and weekends to deal with scheduling issues but they did not have case coordinators to assess client needs and initiate service start-ups. We noted that Prairie Mountain Regional Health Authority had recently received additional funding from the Department to arrange and coordinate home care services (including service start-ups) on evenings and weekends in Brandon.

The timeliness of initial service start-ups for those clients whose needs were identified in the community varied in the files we reviewed. In both regions, initial nursing-service start-ups typically occurred on the date specified on the request form, or the next day. But start-ups for other types of services were less prompt. In WRHA files, services began on average 16 days after assessment and 37 days after referral to the Program. In Southern Health-Santé Sud files, services began on average 11 days after assessment and 31 days after referral to the Program.

When client needs and circumstances change, services need to be adjusted. In the files we reviewed, Program staff scheduled adjustments promptly (generally within a week) 67% of the time (76% in Southern Health-Santé Sud, 52% in WRHA). When adjustments were not prompt, they took an average of 35 days to implement from the time the need was first identified. And 4% of cases had no evidence that requested adjustments were made.

> **Recommendation 17:** We recommend that Southern Health-Santé Sud and WRHA develop plans to improve the timeliness of service start-ups and service adjustments, and monitor progress and compliance with any related standards. These plans should explore:
>
> a. more collaborative discharge planning between hospital and home care staff.
> b. reasons for delays in initial service start-ups and service adjustments for clients in the community.
> c. staffing both case and resource coordinators on evenings and weekends to facilitate service start-ups.

2.3.2 Issues with service reliability, making client back-up plans critical

In Southern Health-Santé Sud and WRHA files with sufficient documentation to assess scheduling, scheduled services were consistent with care plans 91% of the time. Inconsistencies included planned services that were missed in scheduling and that were scheduled more or less frequently than planned, without documented explanations.

Both regions sometimes cancelled visits, making client back-up plans (described more fully in **section 2.2.4**) critical. Neither region monitored how frequently clients had to use their back-up plans. In the files reviewed, cancellations were less than 1% of all visits scheduled over a 3-month period—but this still resulted in significant use of back-up plans. Clients in 38% of the files reviewed were required to use their back-up plans at least once and on average 3.7 times. Individual use of back-up plans ranged from 1 to 13 times. In many cases, clients needed to use their back-up plans because resource coordinators could not fill the scheduled visits. Clients in WRHA also sometimes needed to use their back-up plans on statutory holidays, when only essential services were provided. In both these cases, clients were usually given some notice

(albeit often short) that their back-up plans would be needed. But 12% of the time workers did not arrive for their scheduled visits and the clients had no notice.

Before requiring clients to use their back-up plans, resource coordinators in both regions tried to resolve "unfilled visits" by calling any available home care staff or rescheduling services. WRHA resource coordinators assigned priority codes to non-nursing services to help decide which visits to fill. This helped to identify more essential services when allocating scarce resources. WRHA also used 2 private agencies to fill some of the visits that would otherwise be left unfilled, typically overnight shifts. Southern Health-Santé Sud had no similar arrangements, but Southern Health-Santé Sud management said they intended to consider using priority codes in the future.

Scheduling services was difficult and complex for various reasons. Clients' needs often changed and clients were continually entering and exiting the Program. And several services had to be scheduled within specific time windows (for example, help with getting dressed in the morning or help with medication)—but workers were not always available for the days and times services were needed. At the same time, clients sometimes cancelled visits without any or sufficient notice (for a variety of reasons, ranging from family outings to emergency room visits). And resource coordinators were not always promptly notified when clients were temporarily admitted to hospital or discharged home.

> **Recommendation 18:** We recommend that Southern Health-Santé Sud and WRHA develop plans to improve service reliability and monitor how frequently clients have to use their back-up plans.

2.3.3 Challenges in providing a consistent set of workers for clients

Our review of client files in both regions found that clients were sometimes concerned about many different or unfamiliar workers coming into their homes. A WRHA client survey also noted concerns over the consistency of workers. WRHA guidance directed resource coordinators to minimize the number of workers assigned to a client and to maintain a consistent set of workers for each client. But this was not always possible because of scheduling challenges.

We reviewed the daily schedules of 40 clients (20 in each region) for a selected week. During the week, clients had an average of 30 visits from 8 different workers. The maximum number of workers visiting a client's home during the week was 16 in Southern Health-Santé Sud and 19 in WRHA. This may indicate a problem with consistency of workers. WRHA managed greater worker consistency for weekly bathing assistance.

Not providing a consistent set of workers can be problematic because it takes time for each new worker to become familiar with a particular client's home, medical condition, and care needs. Clients and families may need to spend part of each visit explaining details of the tasks needed (such as where items are kept), leaving less time for workers to provide actual services. And workers may not be familiar enough with a client's regular condition to identify changes and respond appropriately.

Our review of client files and client surveys in both regions showed that some clients and families wanted to know in advance which workers were coming and when—with as few changes as possible to a routine.

> **Recommendation 19:** We recommend that Southern Health- Santé Sud and WRHA monitor the number and consistency of workers assigned to individual clients and assess progress.

2.3.4 Time allotted for tasks not always reasonable

Resource coordinators in both regions are expected to schedule workers' time using regionally-developed standard time allotments for common tasks. They are also expected to adjust the standard time allotments to fit individual client needs. It might be more efficient to have case coordinators flag situations where more time is needed for client-specific needs (for example, to bathe clients with significant mobility or cognition issues) as they would be more familiar with these needs. Resource coordinators are also expected to consider the need for adjustment when workers provide feedback that the allocated time is too short or long.

Overall, Southern Health-Santé Sud's standard task time allotments are more generous than WRHA's. This prompted us to review the standard time allotments for common tasks in all regions. As **Figure 2** shows, these sometimes vary significantly between regions. WRHA policy states that standard task times include travel time, but can nonetheless be adjusted for additional travel time if needed. Regional staff in the other 4 RHAs stated that allotments exclude travel time. Staff also said that allotments are based on historical data and, in some cases, the standards in other regions.

Figure 2: Standard time allotments varied between regions					
Standard task times in minutes					
(before adjustments for client-specific needs)					
Task	**Winnipeg[1]**	**Southern Health- Santé Sud[2]**	**Interlake- Eastern[2]**	**Northern[2]**	**Prairie Mountain[2]**
Bath	25	45	25	45	45-60
Morning care	20	60	20	30-45	30-45
Evening care	20	15-30	20	30	30-45
Medication assistance	10-15	15	10-15	15	15
Meal heat and serve	20	15	20	N/A	15
Meal preparation	N/A	45	45	15-30[3]	30-60
Bulk meal preparation	120	120-180	120	120-180	120-180

1. Time allotments include travel time.
2. Time allotments exclude travel time.
3. Supper may be allotted up to 60 minutes.

Source: RHA home care guidance documents

In Southern Health-Santé Sud, we found that the time actually scheduled for tasks rarely exceeded Southern Health-Santé Sud's standard time allotments, and was frequently less. While there was no file documentation explaining the time reductions, they may have been adjusting overly generous standard task times. We also found cases where case coordinators added tasks to care plans, but resource coordinators did not schedule more time. It was unclear if the time allotted was initially too generous or subsequently too tight.

In WRHA, our file review found that the time actually scheduled for tasks exceeded its standard time allotments about 45% of the time. As there was no file documentation explaining the extra time, it may have been added for individual client needs or additional travel time. During our audit, the union representing provincial home care attendants ran an ad campaign saying that home care services were suffering from tight scheduling and that workers were forced to rush from one client to another. And both Southern Health-Santé Sud and WRHA client satisfaction surveys indicated that about 15% of clients had concerns about workers being rushed.

We reviewed the schedules of 40 staff (20 in each region) for a 1-week period. Seventy-five percent were scheduled to provide services to 2 or 3 people at the same time (for example, scheduled for two 15-minute visits from 9:00 to 9:15 a.m.) at least once in the week. Often there was a gap later in their schedule to catch up, but in 20% of the shifts reviewed (affecting 15 different staff), the sum of the tasks exceeded the length of the shift. Southern Health-Santé Sud management suggested that their resource coordinators may have been double booking visits rather than adjusting the allotted time when staff told them that original time allocations were too generous.

> **Recommendation 20:** We recommend that Southern Health-Santé Sud and WRHA review the reasonableness and consistency of their standard task time allotments to ensure they are appropriate.

> **Recommendation 21:** We recommend that Southern Health-Santé Sud and WRHA require resource coordinators to:
>
> a. clearly explain and document scheduled travel time (for which RHAs may choose to establish standards) and adjustments to standard task times that are made to accommodate client-specific needs.
> b. avoid scheduling multiple visits in the same time slot, as well as shifts where the total task time exceeds the time available.

2.3.5 Significant wages paid for hours guaranteed to staff, but not matched to client assignments

Both regions participated in a province-wide initiative, negotiated between the union and RHAs, that changed a number of home care attendants (as well as home support workers in WRHA) from casual to "EFT" (Equivalent Full-Time) status. EFT workers filled various permanent positions, ranging from full- to part-time. But in all cases, they were guaranteed a set number of hours for specific days and times each pay period.

Under the initiative, 60% of the province's home care workers were expected to be converted from casual to EFT status, with a minimum of 50% in each RHA. Implementation began province-wide in 2011 and was scheduled to be completed in all regions by April 2015. The initiative was expected to increase the recruitment and retention of home care staff.

Southern Health-Santé Sud and WRHA were both unable to fully schedule all EFT workers' guaranteed hours within their set schedules. This was because the set schedules could not always

be easily matched to client assignments. In these cases, EFT workers still received wages for their unscheduled hours. As a result, the regions were paying some staff for hours not worked, while at the same time using private agencies to cover some visits and cancelling others because no workers were available when needed.

WRHA officials told us that EFT workers might spend some of their unscheduled time doing administrative work. They also said that unscheduled time sometimes reflected a temporary suspension of client services (when clients were hospitalized or spending time away from home for other reasons). Or it was a temporary problem as workers transitioned from one client to another in a set time slot.

Because it was not available, we estimated the annual guaranteed hours not matched to client assignments and the related cost. We did this by reviewing 3 pay periods in 2013 and extrapolating the results. Over a 1-year period, the 2 regions could have paid an estimated $4 million ($3.7 million in WRHA, $0.3 million in Southern Health-Santé Sud) for about 231,000 hours not matched to client assignments—while at the same time clients had to use their back-up plans to cover an estimated 16,400 cancelled visits. In addition, WRHA documents showed that private agencies received about $4 million over 12 months to supply home care attendants and home support workers for some of the unfilled visits. Southern Health-Santé Sud did not use private agency services.

Both regions monitored the guaranteed hours not matched to client assignments, but not the related costs or the percentage of total EFT hours unmatched. In addition, WRHA monitored pre- and post-implementation data on client service hours and client satisfaction.

> **Recommendation 22:** We recommend that Southern Health-Santé Sud and WRHA enhance their oversight of the EFT initiative by:
>
> a. developing plans and targets for better matching guaranteed hours to client assignments.
> b. monitoring the cost and percentage of total EFT hours unmatched to client assignments.
> c. evaluating if the EFT initiative is improving staff recruitment and retention.

2.3.6 Gaps in tracking the receipt, investigation and resolution of complaints

It is important for clients and their families to know how to raise concerns about home care services. Clients in both regions were told to contact their case coordinators with any concerns or complaints. Case coordinator phone numbers were listed on clients' copies of care plans.

Neither region required case coordinators to centrally log all complaints so that they could be summarized and reported to management. WRHA logged only complaints received by its client relations unit, which provided a place for all WRHA clients to take any remaining questions and concerns after speaking to people more directly involved in their care. And at the time of our audit, Southern Health-Santé Sud logged only complaints elevated to the manager level, but had recently developed a new policy requiring all complaints "meriting documentation" to be centrally logged. This required subjective assessment of each complaint to see if it merited documentation.

We examined 20 centrally logged complaints (10 in each region). These complaints and their investigation and resolution were adequately documented 65% of the time. When adequate documentation was on file to assess how complaints were handled, they were investigated thoroughly and promptly 74% of the time and adequately resolved 84% of the time.

Because not all complaints were centrally logged, we also looked for complaints in the client files we reviewed. There were service complaints in 50% of the files. In total, families, clients, and home care staff (reporting on other home care staff) raised 136 complaints. Some of the most common were about:

- workers arriving late or not showing up at all.
- tasks not done properly or at all.
- poor communication about RHA-initiated changes to clients' schedules.
- services scheduled on undesirable days or at undesirable times.
- dissatisfaction with a particular worker.

File documentation showed that case coordinators generally followed up on complaints, often by forwarding them to resource coordinators, who were responsible for dealing with staff issues. But in most cases, there was no documentation explaining how or if the complaints were investigated and resolved by the resource coordinators.

We also examined 15 files with self- or family-managed care (an option that allows clients and families to opt out of the regular Program and instead receive funding to hire their own home care workers). We wanted to see why clients and families were choosing this option. About 50% of the time, the decision involved concerns about service quality (such as a concern about a lack of worker consistency, staff not showing up or arriving late, or not receiving service at a preferred time of day). At the time of our audit, WRHA had 552 clients operating under this alternative model and Southern Health-Santé Sud had 34.

> **Recommendation 23:** We recommend that Southern Health-Santé Sud and WRHA centrally track and document the receipt, investigation, and resolution of all complaints, and regularly compile complaint statistics for management review.

2.3.7 Inconsistencies in defining and managing nurse-delegated tasks

Tasks normally performed by nurses were sometimes delegated to home care attendants or home support workers, generally following appropriate training by a nurse and with ongoing nurse supervision. Both regions considered some of the duties performed by their home care attendants to be nurse-delegated tasks, but they were inconsistent in which tasks they labelled "nurse-delegated". For example, WRHA did not consider oral medication assistance a nurse-delegated task, but Southern Health-Santé Sud did.

Both regions also differed in how they managed nurse-delegated tasks. For example, both considered giving eye drops a nurse-delegated task, but they differed in how they managed the related training. WRHA had a nurse provide client-specific training to home care attendants each time this task was delegated for a new client. This was time intensive and could delay service

start-up and interrupt ongoing service. In contrast, Southern Health-Santé Sud had its nurses provide non-client-specific group training on several commonly delegated tasks (including giving eye drops) to its home care attendants. Home care attendants were required to attend this training every year to meet the delegated-task training requirements.

Workers in both regions were required to sign off task sheets when performing health care services, including delegated nursing tasks, to show that assigned tasks were completed. However, we found problems with the sign-offs. In the files we reviewed, 160 tasks should have been signed off by workers over a 3-month period. While 89% of these tasks had related sign-off sheets on file, only 31% were properly initialed for the full 3-month period. And in some cases, staff had signed-off tasks for visits that had not been scheduled or had been cancelled.

WRHA policy stated that resource coordinators, case coordinators and nurses were all responsible for reviewing or monitoring these sheets. Southern Health-Santé Sud had no written policy in this area, but management told us that nurses were responsible for reviewing the sheets. We found no documented evidence of these reviews in either region.

Both regions felt that their differing approaches to nurse-delegated tasks were consistent with acceptable professional practice.

> **Recommendation 24:** We recommend that the Department, in collaboration with RHAs, develop an approach to identify and manage nurse-delegated tasks in the Manitoba Home Care Program consistently, efficiently, and in accordance with acceptable professional practice.

> **Recommendation 25:** We recommend that Southern Health-Santé Sud and WRHA require staff to document reviews of sign-off sheets and related follow-up actions.

2.4   Staff qualifications

2.4.1   Most staff met education requirements

We reviewed a sample of personnel files to ensure that key home care staff (case coordinators, resource coordinators, home care attendants, and nurses) met the RHAs' job requirements.

Both regions required case coordinators to be registered nurses or have degrees in social work or (more recently) other healthcare disciplines. In a sample of 10 case coordinators, all were properly qualified.

Both regions preferred home care attendants (HCAs) with health care aide certificates from recognized post-secondary institutions, but accepted an equivalent level of education and experience. In a sample of 16 HCAs, 12 were certified as health care aides, 2 were trained as licensed practical nurses, and 2 had a high school diploma plus relevant experience. At the time of our audit, regional data showed that 91% of HCAs in Southern Health-Santé Sud were certified, and in WRHA, 94%. Unlike some other provinces, Manitoba does not set a standard health care

aide curriculum for educational institutions or maintain a public registry of accredited health care aides.

Home support workers (employed only in WRHA) had no specific education requirements to be eligible for initial hiring.

Both regions required nurses to be registered with the applicable regulating body (for example, the College of Registered Nurses). In a sample of 10 nurses, all were properly registered.

WRHA required resource coordinators to have post-secondary certificates or diplomas in a health-related field or human resource management; Southern Health-Santé Sud required health care aide certificates. Both regions also required experience supervising staff. But in practice, both Southern Health-Santé Sud and WRHA accepted applicants who didn't meet these requirements, particularly the supervisory experience requirement. In a sample of 10 resource coordinators, 7 lacked evidence of supervisory experience. Most (8 of 10) had evidence in their personnel files showing the educational requirements were met, but 2 lacked sufficient documentation to be assessed.

Both regions required people who supervise nurses to have nursing backgrounds and supervisory experience. In a sample of 6 nurse supervisors, all met these requirements. Southern Health-Santé Sud also required home care experience and a health services management course, although in practice it treated these as preferences.

2.4.2 Gaps in staff training and security checks

Both regions held general and position-specific staff orientation sessions (although Southern Health-Santé Sud's training was not yet standardized between the former Central and South Eastman regions at the time of our audit). Both regions had mandatory training sessions for HCAs (Southern Health-Santé Sud annually and WRHA every 2-3 years), and also offered non-compulsory sessions. The mandatory training covered key areas, such as medication assistance and hand hygiene. In WRHA, home support workers also attended a number of these mandatory training sessions. In Southern Health-Santé Sud, the mandatory training also covered caring for clients with dementia, which was an optional offering in WRHA. However, in a sample of 20 direct service worker files (10 in each region), only 2 had documentation showing participation in all mandatory training over the past 3 years.

Both regions required staff to pass a criminal record check (including pardons), child abuse registry check, and (starting in May 2013) an adult abuse registry check. But in a sample of 40 personnel files (10 case coordinators and 30 direct service staff), only 19 had documentation showing all required checks had been done and 10 were missing all security checks. In addition, there were documented adult abuse registry checks for only 78% of case coordinators hired between May and December of 2013. While missing documents may have been misfiled or discarded, staff in WRHA confirmed that in some cases the checks were not done.

> **Recommendation 26:** We recommend that Southern Health-Santé Sud and WRHA monitor whether the mandatory training and security-checks for home care staff are being done and properly documented, and remedy any gaps.

2.4.3   Conflict-of-interest processes require better management

Both RHAs require staff members to sign conflict-of-interest forms when hired, and to declare any conflicts as they arise. Southern Health-Santé Sud and WRHA management said that declared conflicts were typically handled by re-assigning clients.

Case coordinators are the home care staff most likely to encounter potential conflicts of interest because they assess client needs and approve client services. In a sample of 20 case coordinator personnel files (10 in each region), only 7 had conflict-of-interest forms. Also, our client file review found one conflict-of-interest situation that was not properly mitigated, although we did not note any resulting special treatment of the client.

> **Recommendation 27:** We recommend that Southern Health-Santé Sud and WRHA:
>
> a.   ensure that they receive and keep signed conflict-of-interest forms for all staff.
> b.   require all declared conflicts and their resolution to be documented.
> c.   periodically remind staff of their responsibilities to declare and manage actual and potential conflicts of interest as clients are assigned.

2.5   Quality assurance processes and management information

2.5.1   Few file reviews and home visits performed

Both regions expected supervisors to perform various file reviews and home visits (where supervisors observe staff providing care in a client's home) to give staff feedback on their performance, note common issues, and assess staff training needs. These file reviews and home visits are important quality assurance processes because not all clients are comfortable raising concerns and making complaints.

Supervisors were expected to review a sample of client files when completing annual performance appraisals for case coordinators in both regions, as well as when completing appraisals for WRHA nurses. But in a sample of 30 personnel files, there were no client file reviews in the Southern Health-Santé Sud personnel files and only 2 in the WRHA files (both for case coordinators).

WRHA had other ways to oversee the quality of work done by nurses. Nurse supervisors completed annual caseload reviews with each nurse. And staff responsible for training nurses were starting to periodically audit nursing files. These reviews and audits assessed documentation, compliance with policies, and the completion of nursing assessments and care plans.

Both regions also had other quality assurance processes for case coordinators, although in very limited and specific areas. WRHA case coordinators were required to take an annual web-based test that assessed consistency in identifying client needs. But WRHA statistics showed not all case coordinators participated each year (68% in 2013, 95% in 2012). And Southern Health-Santé Sud management said that the manager of home care nursing performed undocumented face-to-face file reviews with case coordinators in some communities to see if they were properly assessing and documenting clients' nursing needs.

In both regions, supervisors of direct service staff (home care attendants, nurses, and home support workers) were required to observe staff during home visits to gather information for annual performance appraisals. But in a sample of 30 personnel files, there was no evidence of any visits in Southern Health-Santé Sud files and only 3 documented visits in WRHA files.

Management in both regions acknowledged that file reviews and home visits were not always getting done; they said that issues with workloads and staff turnover were contributing factors.

Only the WRHA's nursing file audits used a standard template. Ideally, all file reviews and home visits would be documented using standard templates. The templates would ensure consistency, coverage of all key areas (including compliance with related policies and guidelines), and proper documentation. They would also allow the results of file reviews and home visits to be compiled to identify areas where staff need more training or guidance.

Our audit work highlighted problems with the timeliness and quality of assessments and care plans, the timeliness of service start-ups, the reliability and continuity of on-going service delivery, incomplete task sign-offs, overly-tight staff schedules, and the handling of complaints. These key areas should be periodically examined during file reviews. And the selection of files for review should be weighted towards higher-risk clients.

> **Recommendation 28:** We recommend that Southern Health-Santé Sud and WRHA improve their quality assurance processes by:
>
> a. completing the client file reviews and home visits required, particularly for higher-risk clients.
> b. developing standard templates to ensure client file reviews and home visits are done consistently and cover all key areas.
> c. compiling the results of file reviews and home visits to discern trends and identify areas where staff may need more training or guidance.

2.5.2 Variety of management information, but little related to service quality

As **sections 1.3.1 and 2.3.5** explain, both regions tracked some service volume information to report to the Department, and some information on the EFT initiative. They also had a variety of other management information, described below. But very little of this information related to service quality or client outcomes.

Management in both regions tracked and monitored information on direct staff time. They had reports detailing overtime, sick time, and vacation time. Southern Health-Santé Sud also tracked kilometers travelled. Management in both regions said they also monitored workloads. Caseloads for case coordinators averaged 95 in Southern Health-Santé Sud, 106 in WRHA. And the number of staff assigned to supervisors was generally less than 35 in both regions, but a single person in Southern Health-Santé Sud supervised all nurses—about 100 at the time of our audit.

Although both regions used the same scheduling system, only WRHA regularly extracted management information—likely because it had used the system longer and had support staff to run reports. WRHA's reports included information on outstanding service requests, unfilled visits,

and visits cancelled by clients without any notice. WRHA could also generate reports on client demographics from its more sophisticated client assessment tool (RAI-HC) that Southern Health-Santé Sud could not produce. For example, WRHA had reports showing how client complexity had increased in recent years.

Both regions tracked the number and types of home care occurrences (any events, accidents or circumstances that resulted or could have resulted in injury to home care clients or staff, or damage to property or equipment). Reported occurrences included items such as medication errors, client falls, and cases of aggressive or abusive behaviour. Southern Health-Santé Sud reported about 900 annual occurrences, WRHA only 163. WRHA management said this was likely due to underreporting. The most commonly reported occurrence involved medication.

Only Southern Health-Santé Sud regularly conducted home care client satisfaction surveys. However, at the time of our audit, WRHA was surveying a small sample of clients to measure the impact of the EFT initiative. While these surveys found that clients were generally satisfied with the Program, clients often raised issues when answering open-ended questions about what could be done better. Some of the common concerns were about:

- a lack of communication about schedules and workers (mostly WRHA).
- a lack of consistency in staff or care.
- services not being provided on preferred days or at the preferred time of day.
- late or rushed workers.

The surveys lacked specific questions about satisfaction with wait times for assessments and service start-ups, the continuity of staff, and the number of times back-up plans had to be used.

Section 1.3.1 describes the statistical information the Department requires from the RHAs and the need to ensure that this information is useful, complete, and accurate. And **Section 1.3.2** describes in greater detail the types of service quality and client outcome measures that would help the Department monitor RHA performance. Recommendations made to the Department in these 2 sections cannot be implemented without the assistance of the RHAs and are equally useful to RHA management.

Summary of recommendations

Departmental oversight

1. We recommend that the Department forecast the increased demand for home care services likely to result from the expected growth in the senior population so that, within the context of its planning for the healthcare system as a whole, it can understand the staff and financial resources needed to sustain Program services over the long term.

2. We recommend that the Department:

   a. specify which direct services (if any) RHAs must make available to home care clients, no matter where they live.
   b. make it clear in all their published materials describing home care services which services RHAs must provide (if any) and which are optional.

3. We recommend that the Department make its home care standards and policies public, as done in other provinces.

4. We recommend that the Department identify key provincial home care standards and require RHAs to review their compliance with these standards and report the results to the Department.

5. We recommend that the Department:

   a. review the home care monthly statistics it requires from RHAs to ensure the statistics will provide all key information needed to effectively monitor and analyze Manitoba Home Care Program performance.
   b. monitor all key home care information it receives for completeness and reasonableness, particularly information being publicly disclosed in its annual statistics report.
   c. analyze RHAs' statistical reports, in conjunction with their financial reports, to identify and follow-up variances from expected results, anomalies, and longer-term trends for the Manitoba Home Care Program.

6. We recommend that the Department, in consultation with RHAs, define and monitor performance measures for service timeliness, service reliability, and key client outcomes for the Manitoba Home Care Program.

7. We recommend that the Department work with RHAs to expand and improve public performance reporting on the Manitoba Home Care Program.

Southern Health-Santé Sud and WRHA delivery of services

8. We recommend that Southern Health-Santé Sud and WRHA work with the Department to strategically promote greater awareness of Manitoba Home Care Program services to doctors and the public.

9. We recommend that Southern Health-Santé Sud and WRHA develop plans to improve the timeliness of at-home client needs assessments and monitor progress in meeting their timeliness standards.

10. We recommend that WRHA review its central intake processes to ensure staff flag all urgent referrals and avoid unnecessarily duplicating the needs assessments done by case coordinators.

11. We recommend that Southern Health-Santé Sud and WRHA investigate why required client needs assessments are not always done or fully completed, and remedy this.

12. We recommend that Southern Health-Santé Sud and WRHA ensure that case coordinators have the training and tools to:

    a. assess and negotiate, as consistently as possible in similar circumstances, the support that family members can realistically be expected to provide for home care clients.
    b. identify all possible third-party providers so coordination of home care services and cost recoveries can be arranged and properly documented.
    c. adequately support and document the reasons for Program non-admissions.

13. We recommend that Southern Health-Santé Sud and WRHA work with the Department to:

    a. clearly define "available community resources" and clarify if client ability to pay is relevant when assessing the availability of a community resource.
    b. develop processes to verify client ability to pay if it is relevant in assessing the availability of a community resource.

14. We recommend that the Department develop a plan for province-wide implementation of the RAI-HC client assessment tool.

15. We recommend that Southern Health-Santé Sud and WRHA ensure that client care plans:

    a. meet all clients' assessed needs, and only those needs.
    b. clearly state the frequency or amount of service to be delivered.
    c. specify a reliable back-up plan that can be actioned as required.
    d. are signed by clients or their designates to show they reviewed and discussed them.
    e. are updated at least annually, using a formal reassessment process that prioritizes higher-risk clients.

16. We recommend that Southern Health-Santé Sud and WRHA ensure that file documentation for client care plans includes:

    a. supervisory approval when planned services exceed established protocols.
    b. a copy of the paper care plan signed by clients or their designates.

17.   We recommend that Southern Health-Santé Sud and WRHA develop plans to improve the timeliness of service start-ups and service adjustments, and monitor progress and compliance with any related standards. These plans should explore:

   a.   more collaborative discharge planning between hospital and home care staff.
   b.   reasons for delays in initial service start-ups and service adjustments for clients in the community.
   c.   staffing both case and resource coordinators on evenings and weekends to facilitate service start-ups.

18.   We recommend that Southern Health-Santé Sud and WRHA develop plans to improve service reliability and monitor how frequently clients have to use their back-up plans.

19.   We recommend that Southern Health-Santé Sud and WRHA monitor the number and consistency of workers assigned to individual clients and assess progress.

20.   We recommend that Southern Health-Santé Sud and WRHA review the reasonableness and consistency of their standard task time allotments to ensure they are appropriate.

21.   We recommend that Southern Health-Santé Sud and WRHA require resource coordinators to:

   a.   clearly explain and document scheduled travel time (for which RHAs may choose to establish standards) and adjustments to standard task times that are made to accommodate client-specific needs.
   b.   avoid scheduling multiple visits in the same time slot, as well as shifts where the total task time exceeds the time available.

22.   We recommend that Southern Health-Santé Sud and WRHA enhance their oversight of the EFT initiative by:

   a.   developing plans and targets for better matching guaranteed hours to client assignments.
   b.   monitoring the cost and percentage of total EFT hours unmatched to client assignments.
   c.   evaluating if the EFT initiative is improving staff recruitment and retention.

23.   We recommend that Southern Health-Santé Sud and WRHA centrally track and document the receipt, investigation, and resolution of all complaints, and regularly compile complaint statistics for management review.

24.   We recommend that the Department, in collaboration with RHAs, develop an approach to identify and manage nurse-delegated tasks in the Manitoba Home Care Program consistently, efficiently, and in accordance with acceptable professional practice.

25.   We recommend that Southern Health-Santé Sud and WRHA require staff to document reviews of sign-off sheets and related follow-up actions.

26.   We recommend that Southern Health-Santé Sud and WRHA monitor whether the mandatory training and security-checks for home care staff are being done and properly documented, and remedy any gaps.

27.   We recommend that Southern Health-Santé Sud and WRHA:

   a.   ensure that they receive and keep signed conflict-of-interest forms for all staff.
   b.   require all declared conflicts and their resolution to be documented.
   c.   periodically remind staff of their responsibilities to declare and manage actual and potential conflicts of interest as clients are assigned.

28.   We recommend that Southern Health-Santé Sud and WRHA improve their quality assurance processes by:

   a.   completing the client file reviews and home visits required, particularly for higher-risk clients.
   b.   developing standard templates to ensure client file reviews and home visits are done consistently and cover all key areas.
   c.   compiling the results of file reviews and home visits to discern trends and identify areas where staff may need more training or guidance.

Web Version

Response of officials

Manitoba Health, Healthy Living and Seniors (the Department), Winnipeg Regional Health Authority (WRHA), and Southern Health-Santé Sud would like to thank the Office of the Auditor General (OAG) for its review of Home Care. The detail provided in the review will help to inform current and future efforts to build and strengthen Home Care from the policy (provincial) and regional (operations and management) perspectives and further support delivery of responsive, effective, sustainable and accountable home care services to the citizens of Manitoba.

First developed in 1974, Home Care was designed to help individuals live with dignity in their own homes for as long as safely possible as it was, and continues to be, recognized that some people may require ongoing health care services or help with activities of daily living, but not necessarily at the level of care provided in a hospital or personal care home (PCH). Services provided through Home Care are intended to supplement the role that informal caregivers (e.g. family, friends) play in the provision of that care. In addition to care/support services, Home Care facilitates the transition of individuals from community to facility-based care as care needs necessitate.

Manitoba has been a leader in Canada in introducing new and innovative services to assist its residents to remain in their homes as they age. In 2006/07, the Aging in Place Strategy directed provincial efforts to build and enhance community-based/housing supports. Commitments for enhancements to Home Care made in 2011 – enhanced home care service level (increase in weekly hours from 50 to 55) and increased funding for Specialized Supports and Self and Family Managed Care) are now fully implemented and have helped to address service volume pressures. In 2014, *Advancing Continuing Care: A Blueprint to Support System Change* (*The Blueprint*), developed in collaboration with key stakeholders, was released and is intended to provide a comprehensive approach to address priority service areas with the goal of sustainable health programs and services.

The Blueprint highlights seven Areas of Action[1] that align with the Department's priorities and goals. Four action areas target community/home-based supports:

1. Helping individuals to stay at home by investing in community supports and focusing on wellness, capacity-building and restoration when delivering home care services;
2. Improving access to home care services;
3. Strengthening and promoting co-operation among health care partners to keep people at home; and
4. Committing to dedicated health technology to help improve the quality and co-ordination of care and in making informed decisions and policy.

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[1] The remaining three areas of action are related specifically to PCHs (Ensure there are enough long term care beds to meet the needs of Manitobans and Develop new, innovative ways of delivering services to improve health outcomes for residents of PCHs) and housing options (Strengthen and expand options for community-based housing as alternatives to PCHs).

Particularly in recent years, reliance on Home Care to support individuals in community to prevent premature admission to PCH or avoid unduly long acute care hospital stays has significantly increased. Home Care client numbers have grown steadily. Additionally, the amount and acuity of required care/support services for those clients collectively have likewise increased.

Many of the recommendations contained in the report are reflective of a program upon which volume and service pressures have outpaced program evolution and resourcing, a situation of which the Department and Regional Health Authorities are aware. Regional Health Authorities have responded to these service pressures, as they present in their region, which has contributed to some variation in available services across the province. Both the Department and Regional Health Authorities agree a review of the recommendations will be beneficial in sharing approaches and best practices in response to service pressures.

At the Department level, the audit recommendations collectively address the need for improved data collection (to inform projections of future service needs) and consistent accountability measures (to demonstrate the impact of Home Care services and support quality, consistent service province-wide), and the need for increased transparency of services to the public. At the regional level, recommendations are primarily reflective of the latter two themes.

The Department, the WRHA, and Southern Health-Santé Sud accept the findings detailed in the OAG report.

The WRHA has initiated several improvements to regional operating processes, which address regional-specific recommendations as outlined in the OAG report, including referral processing, the timeliness of client assessment and initiation of services, use of human resources and quality/safety accountabilities. The WRHA values the importance of delivering quality home care services to support individuals in the community. To that end, the WRHA will work collaboratively with the Department and other regional health authorities to develop common standards and improve home care services to the benefit of clients and their families and caregivers.

Southern Health-Santé Sud has initiated improvements in a number of Home Care operation areas as recommended in the audit, with activities to date addressing service and documentation standards, including a means to identify service gaps and staff qualifications/training. Southern Health-Santé Sud has many processes and procedures in place to ensure consistency and accountability and continues to strive to improve quality, safety and accountability via work that is planned or currently underway. Southern Health-Santé Sud continues to work with Accreditation Canada to meet the established standards for Home Care and, most recently, has received Accreditation status. Southern Health-Santé Sud is committed to collaborating with the Department to enhance awareness of the Home Care Program services and improve the provision and standard of home care services delivered.

The Department is committed to work, in conjunction with all the Regional Health Authorities, to address the provincial scope of these recommendations. Priority initiatives, as defined in *The Blueprint* have been initiated and the Department is committed to ongoing efforts to address the OAG recommendations.