Media Release
ASCHA BACKGROUND INFORMATION
Home Care Contracts in Supportive Living
June 17, 2013

Alberta Health Services (AHS) issued a Request for Proposal for organizations interested in Home Care contracts in the Edmonton and Calgary Regions. The contracts were recently awarded and we are concerned about the quality of home care services to seniors and the pending loss of integrated, efficient and effective home care delivered by on-site staff in supportive living.

In the AHS Calgary Zone there are many Integrated Supportive and Facility Living (ISFL) contracts where Home Care (HC)/Private Assisted Living (PAL) and Designated Assisted Living (DAL) services are integrated into one (DAL/PAL) contract under Alberta Health Services. These integrated contracts were excluded from the Home Care RFP. Edmonton Zone took a different approach to Home Care services in congregate living settings and the industry now has yet another anomaly. There should be consistency in the way the industry manages contracts for quality, efficiency and effectiveness of care delivery with a person-centered focus.

Below we will describe the current practice and what will happen in the near future based on the shift in Home Care contracts. We have also described the big picture perspective to both AHS and Supportive Living residences, evidence, recommendations for consideration and outlined the requested action.

Current situation (before RFP)
- On-site staff had a faster reaction time, greater flexibility to change, and the ability to adapt to resident needs.
- On-site workers were well positioned to notice health decline scenarios and raise awareness/react/recommend residents for support before a crisis occurred.
- Trained on-site staff was available to take care of unexpected incidents and unscheduled needs and was available for ongoing communication with residents, their families and health professionals as needed.
- A site could manage residents that were hard to house, had mental health issues, and behaviors with the skilled staff they had on site. Staff from all departments (e.g. dietary, janitorial, health care) could work together to support residents.
- A site provided a residential model focused on the social determinates of health including a range of hospitality and accommodation services.
- 100% of on-site staff time was spent providing home care supports and services; with no need to travel from site to site incurring travel and travel time expenses.
- Sites who had integrated Designated Supportive Living (DSL) and Home Care contracts could manage most health related supports with in house staff; an excellent blend of services.
- These sites could manage medication reconciliation, high alert and PRN (Pro re nata = as needed) medication delivery with Licensed Practical Nurses in integrated sites.
- Sites were in a position to manage behaviours, redirection and appropriate cueing of residents.
- Sites had Home Care staff on site to assist with evacuation if required.
**Near future (starting August 1, 2013)**

- Delayed reactivity to crises as contracted providers have to learn about the residents and their preferences.
- Increased potential for different care workers from one visit to another with numerous care providers coming and going from the congregate living residence to provide supports to multiple residents.
- Residents are anxious and fearful of dealing with new caregivers and a new system; trust is broken.
- Management and site staff will now have less frequent contact with residents, will know less about their residents’ health needs and will be less able to assist in meeting their individual needs on an ongoing and timely basis.
- Supportive Living sites will be much less likely to admit residents with behaviors and mental health issues, as these individuals are hard to house without having the support of Health Care Aides and Licensed Practical Nurses on site to deal with spontaneous issues that arise.
- Flexibility in home care support services will be lost, as staff will not be available to take care of unscheduled resident needs. This may increase 911/ambulance calls, visits to emergency and acute care admissions for a variety of reasons like unexpected falls or health related issues. This will increase healthcare costs.
- This change will cause a total loss of operational integration on site.
- Many current residents will have to be moved to a higher level of care immediately and others sooner than expected due to the loss of the resident (person) needs being managed by the site.
- Caregivers will have numerous Home Care clients which will increase the expense of travel from site to site and the cost of the time during travel will also be extensive.
- This adds complexity for both the resident and their families as they need to liaise with the housing operator and the home care provider. The perception is often that the housing provider is responsible for all services and this could impact the reputation of the housing operators and increase the risk of litigation.
- When the contracted Home Care providers are no longer on site or have been unable to get to the site to provide care, families look to the housing provider for answers for the lack of service.
- With sites that have Designated Supportive Living (DSL) units and have now lost their Home Care contracts, it may not be feasible to manage from a human resource or economical perspective. There is a risk that these sites will give back their DSL contracts.
- Medication reconciliation and management becomes increasingly difficult with multiple care providers increasing the risk of error to residents.
- Home care staff may not be on site to assist with evacuation if required.

**BIG PICTURE PERSPECTIVES**

**Alberta Health Services**

- While it may be easier to deal with fewer contracts, the delivery of home care in a congregate living setting is very different to delivering home care supports in single family dwellings.
- The reality that on-site staff enhances the cognizance of the needs of the resident living in a congregate living setting and allows for flexible care on an as needed basis, as well as the effectiveness and efficiency of on-site staff must be considered.
- AHS may save $18.5 million dollars in this area but costs will likely increase in other areas (e.g.; acute care, 911, emergency, etc.) As well, most of the $18.5 million savings comes from paying providers less (about a 7% cut), not moving to fewer providers.
- This decision does NOT allow for the flexibility in providing care that is person centred.
**Supportive Living residences**
- The move to contracted service providers is not conducive to person-centered housing.
- Housing providers will lose connection with the holistic health and wellness of residents residing in their congregate living settings.
- The relationship between the housing provider and the resident will be broken down when they are no longer involved in the resident’s care. Often the Health Information Act limits good communication which detracts from resident care.
- AHS “Destination Home” program is in jeopardy as housing providers will refuse to take residents back if they are not in stable condition due to the risk to the resident, staff and organization.
- When resident needs are not fulfilled by contract providers due to lack of staff, weather or during regular day to day operations (e.g. re-directing/cueing), housing providers are the only ones on site and are left to bear the wrath of residents and family members. Housing providers are also put in a tough position during crisis intervention situations. There will likely be many more calls to EMS since staff on-site have no training or mandate to provide care.
- Layoffs of long term employee’s due to AHS decisions will cause a considerable financial burden to housing providers with no timely ability to adjust their business plans.

**Evidence**
There is evidence of practice for the quality of consistent assignment of the same caregivers consistently caring for the same residents almost every time caregivers are on duty. Consistent assignment is a practice recommended by many policymakers, government agencies, and industry advocates. The association of consistent assignment of nurse aides with the quality of care and quality of life of nursing homes residents is examined in “The Influence of Consistent Assignment on Nursing Home Deficiency Citations”, The Gerontologist, Vol. 51, No. 6, 750-760. As a result of this research, consistent assignment has been developed as a preferred practice based on several assumed incumbent benefits, including resident care preferences, staff preferences, lower staff turnover, and better quality of care. The empirical evidence showed that the quality of life deficiency citations were significantly lower in facilities with the highest levels of consistent nurse aide assignment.

**Recommendations for consideration**
The small percentage of cost savings against the whole AHS budget, measured against the safety and security of the residents; efficiencies and effectiveness of the quality of care needs to be considered. The impact of increased calls to 911 and visits to emergency need to be factored in as housing providers no longer have access to Home Care staff to deal with crises. The Continuing Care industry working together with Alberta Health Services collaboratively can provide a flexible and continuing improved method for the delivery of care when they are providing the Home Care supports on site.

ASCHA urges Alberta Health Services to reconsider its approach to Home Care Contracts. Supportive Living operators who have DSL contracts should have first right of refusal for site based Home Care contracts similar to the integrated ISFL model in the Calgary Zone.

**Person-centered housing honours the individual’s needs, desires and choices to maintain and enjoy a wholesome, vibrant lifestyle in congregate living settings.**