Home Support: An Overview

"Home Support" (now called "Community Health Work") refers to one aspect of Home Care--"health and social services designed to support those who are ill, disabled or dying to live at home or their residence of choice" (MacAdam). Home support complements nursing and therapeutic services, and is usually carried out by non-professionals with a range of skills and education. Such services include: personal care such as assistance with toileting (peri care), bathing, getting up and dressed, and returning to bed, housekeeping, meal preparation, laundry, assistance with shopping or errands and help with medications. Home support may also include companioning and respite for family caregivers.

Policy Environment of Employment and Work in the Home Support Sector

One cannot discuss the labour market for the Home Support sector without discussing the "politics" of Home Care. Decisions and policies created by government have a direct bearing on the number of home support jobs there are in the regulated system.

- Both Provincial and Federal governments have created formal policies and informal practices that seek to replace acute care recovery and residential long term care with "home care", of which home support is an integral part.
- There is no National Home Care policy and "Home Care" is not covered under the Canada Health Act, and so its funding through Federal Transfer Payments is not guaranteed, even though it is seen as "the future of Health Care".
- Recent Provincial policies have sought to place home care as a "complement to" family care-giving. The subtext to this is an assumption that the presence of family equates with that family's ability to give care—an idea that ignores the reality for many families.

Funding available for Home Care has remained static over recent years, while the population has aged and grown more frail, increasing the client load. Public funding is administered by: LongTerm Care, Ministry of Children and Families, Department of Veterans Affairs Canada, WCB, ICBC

The British Columbia Ministry of Health Planning is currently engaged in an exercise to develop a 10 year "rolling" plan to ensure adequate Health Human Resource staffing. This planning includes Home Support.

A History of Home Support in the Capital Region

Home Support in the Capital Region began during the 1970's as a community based voluntary movement. It quickly grew in scope with community groups and individuals creating non-profit mechanisms for providing service. During the 1980's, there was a period of great expansion that saw the establishment of many local for-profit home support agencies—often arising out of the mushrooming case-load of a single freelance home support worker. It was also during this decade that credentialling of the work began with the introduction of a Provincial training curriculum. Multinational home support agencies began to move into the area about this time, and workers began a drive to unionize. Public Sector Funding was plentiful, with the Ministry of Health, through the department of Long Term Care subsidizing the provision of a wide range of services to many people. Clients were able to choose the agency that would provide their care.

With financial retrenchment in the 1990's, the Ministry of Health reorganized by establishing Health Regions and Authorities throughout the province. Regionalization had the unforeseen negative effect of reducing "portability" for clients—particularly adults with physical disabilities. Now, if a young disabled adult who was receiving service in Vancouver wished to move to Victoria (for a job, or to study) s/he had to be re-assessed by the long term care office in the new authority, before being able to acquire service.

In the Capital Regional District, until 2002, the health authority was the Capital Health Region, which governed a geographic area stretching north of Greater Victoria to Port Renfrew, including the Saanich Peninsula and the Southern Gulf-Islands, administered all health-related programs including home support.

The CHR instituted a local "mini-regionalization" of home support services, in which every three years, agencies bid for a service contract with CHR in a particular geographical area. The contract is only awarded to agencies with certified, unionized staff. Only one agency in each area could provide service funded by CHR . Clients could no longer choose their home support agency. The number of home support agencies shrank. (exact #s coming)

Around 1995, in order to reduce expenditure, CRH instituted new eligibility rules for clients and a "priority screening system" to streamline the assessment process. These innovations reduced the number of clients in the CHR from 7800 in 1995 to 3000 today. Now, it is only the "oldest old" (85+) and the most at risk who are assured of service. Many elderly people who identify themselves as needing home support are not able to access services they can afford.

- **Priority Screening Tool:** In the early 1990's, all potential clients were referred to a case manager, who made a home visit to assess their needs and eligibility. By seeing the potential in their home, the case manager could get a clear sense of their support systems, quality of food and ability to cope with basic living tasks. The priority screening tool now in use is administered by a clerk over the phone, and awards points for various "conditions of risk". It is up to clients to clearly state their difficulties in order to achieve a high score. As the natural tendency of most people is to minimize their needs, many people who would have been found elibigible by a home visit, are screened out by the tool. This includes many people with variable conditions such as Parkinsons, and MS, as well as those with head injuries, who may misunderstand the questions put to them.
- **Eligibility Rules:** Essentially, the definition of "need" has changed. During the early 1990's home support cleaning services were seen as "needed" to prevent more rapid deterioration of health. Since 1995 "need" has been increasingly defined in terms of risk management—prevention of falls in the bathtub, for example. The risk of eventually getting sick from living in unhygienic conditions is seen as less pressing than the risk of an immediate hip-breaking fall. Someone with the former is unlikely to get service, while someone with the latter most likely will. For this reason, the type of services offered have been reduced to personal care, help with medications and other "home nursing" tasks. Although some cleaning services are in some circumstances included as part of the personal care service, this is now defined as "risk management" cleaning—spills, bathrooms, removal ofrotting food in fridge and (sometimes) vacuuming. Such cleaning occurs as part of a whole care plan only if there is no other way of getting it done, ie.volunteers, family. Similarly, meal preparation is only provided under certain conditions. Increasingly, clients are encouraged to use alternate food services such as Meals on Wheels—an expensive option to some, such as MS clients on Disability 1.
- **Hours Cap:** Reduction in service has also been achieved through capping the number of hours for which can client can be eligible for service per month. Currently 120 hours is the maximun allowable, except in the case of someone requiring Palliative Care in the home—these clients are eligible for 24 hour care for one month.

In January of 2000 the Ministry of Health reduced the number of Health Authorities in the province. CHR was replaced by the Vancouver Island Health Authority (VIHA), which oversees all of Vancouver Island and part of the Central Coast. VIHA currently carries a deficit of $70 Million.

A Sector Defined

The Home Support Marketplace: Three Sectors in One

The Home Support market place can be divided into 3 sections—

- public, or government funded (actually a combination of client share, based on tax returns and government subsidy) sector in which standards of service are regulated
- private, unregulated sector, in which fees for service are paid directly by clients or their families.
- "no service" sector in which reside people desiring home support who are unable, for various reasons, to access it.

Public Sector

In the Public sector, home support services are subsidized or paid outright by the Ministry of Health, through the authority of Continuing Care, administered by VIHA. Other government ministries, such as the B.C. Ministry of Children and Families and Department of Veteran's Affairs Canada, WCB and ICBC may also pay for home support services. Most clients pay a portion of the service cost, determined by income. Approx. 30% of total agency revenues are client portion.

In the Capital Regional District, the cases of approximately 3000 home support clients are governed by VIHA, which carries out administration.

- Clients contact a single entry point
- Priority screening program calculates various risk and income factors, score on this program determines eligibility for home support services
- If a client is eligible, a VIHA Case Manager visits him or her at home and determines the type and extent of service required, and then contracts with a designated home support agency to provide that service.
- In some cases the Case Manager may decide that the client is eligible for the Community Supports for Independent Living program. The client then will receive a lump sum payment and negotiate his/her own contracts for service.
- Client is liable for part of payment—share determined by previous year's income. Costs of care for people receiving assistance are fully subsidized.
- If a client is not eligible s/he may be referred to the private sector to make his or her own arrangements.
- Funding to agencies is attached to clients as billable hours.

Home support is costed as an hourly fee for service. In addition to paying the community health worker for services to clients, this fee also covers a portion of salary for nurse supervisors, schedulers, and other office staff, as well as inservice training, CPP, EI, insurance and health benefits.

Public Sector employers include contracted non-profit and for-profit Home Support Agencies, Supportive Living Projects, other experimental service delivery methods, and clients on the Community Supports for Independent Living (CSIL) program. Except for the CSIL clients, these are unionized workplaces, and workers must have recognized Home Support/ Resident Care Attendant training. Services provided include:

- Personal care
- Housecleaning: if part of care plan or care-giver respite
  if funded by Dept. Veteran's Affairs
- Food preparation only may be offered if there is a reason (ie. mentally ill person not eating) but usually it is part of whole care plan.
- Overnight childcare to families in crises

- Assistance with children who have special needs
- Supervised access to children.
- Household management life skills,

Home support Agencies bid for the VIHA contract every three years. Contract requirements are price, accessibility, safety, continuity of care. The Supportive Living projects are contracted separately, and Community Supports for Independent Living (C.S.I.L) funding goes directly to the client, who hires independently.

Private Sector

In the Private Sector, home support services are paid for directly by the clients or their families or, in some cases, ICBC or WCB. Although clients rejected by VIHA may be referred to a list of service providers, generally people seeking home support services from the private sector must do their own leg-work. Telephone directories, service directories such as that compiled by Seniors Serving Seniors, S.W.A.P. ,(UVIC) and other volunteer agencies, Newspaper advertisements, word of mouth and lists held by Hospital Liason nurses and other health professionals all may be examined in order to find the desired help.

The Employers in this sector include for profit agencies and freelance home support workers.

"No Service" Sector

At present, anecdotal evidence from interviews suggests that there is a large population of potential clients who are unable to access home support services. While the size of this group is uncertain, Hollander (Evaluation of the Maintenance and Preventive Function of Home Care), reports that 532 people who were receiving home support were cut from "low level" service in 1995. 7,367 continued to receive service at that time. Since then, however, estimates indicate that numbers of clients receiving service have declined to the present level of approximately 3,000. This loose estimation suggests that a pool of about 4000 people including the "young elderly", people with MS and Parkinson's, people with care givers at home, the head injured, younger adults with disabilities and dependent children over 19 years would benefits from some form of home support—probably at the lower levels--, housekeeping, laundry, assistance with shopping or errands, and companion services.

Clients—A Snapshot

Clients for home support vary from very frail elderly people in their nineties, to middle aged people with chronic diseases such as MS, to adults of any age with disabilities such as paraplegia, quadriplegia, or brain injury. Clients present a mix of challenges, including hearing, sight, speech and cognitive deficits associated with ageing as well as physical disabilities. Clients currently receiving home support in the private or public sector break down as follows.

	A	B	C	D	E	F	G	H	I	J
frail	50%	90%	90%	95%	95%	100%/85%	5%	75%		10%
elderly	85-90%	90%	90%	95%	95%	85%	95%	100%	50%	65%
disabled	16/340	5%	2%?	.5%	0	10%	0	25%		10%
HIV/AIDS)	1-2%	n/a	n/a	0	0	0	0	10%		0
palliative	96/340	2-3clients	n/a	6%	30%/95	5-10%	10-15%			10%
Dementia	165/340	20%/90%	n/a		0	45-50%	15%/95%	50%		10%
mentally ill	1-2%	2-3clients	7%	.5%	0	15-20%	0	2/45		5%

In our survey of clients we came up with the following "snapshot"; 70% of those currently not receiving service felt they needed home support. 62.5% of those receiving subsidized support, felt they needed more—mostly cleaning services. Shaded areas in the table below indicate clients who feel they need more support. 100% of these wanted housecleaning services such as vacuuming, kitchen and bathroom cleaning, laundry, etc.

Need for Support

37% Paying Privately	33% Subsidized Support		20% No Support		10% Both*
		62.5%		70%	

*Receiving subsidy and paying for extra

Hours per Week Needed

43% need 1-3 hours per week	20% need 3-5hours/wk	5-7 hours/wk	7-10 hours/wk

Ability to Pay

48.9% can pay for support *	
75% can pay $10-15/hr	25% can't pay

*As this percentage includes those already paying privately, it is believed to be higher than the population at large.

HOME SUPPORT SERVICES DESIRED AS REPORTED BY CLIENTS, WORKERS, COMMUNITY AGENCIES, H.S. AGENCY MANAGERS

Clients, workers, directors of community client groups, managers of home support agencies and focus group participants were asked about what services and quality of service clients require. People responded as per the chart below.

	Clients	Community Agencies	Workers	H.S. Managers
TASKS	Cleaning-vacuuming, laundry, refridgerators, stoves, kitchens and bathrooms. Companioning to Dr., shopping, appointments Food Preparation	Poratable physical assistance with daily living at home (including cleaning) and in the community. Food preparation Housekeeping		Yard work, home maintenance, respite, transportation, handyman, assistance to dr. appt., housekeeping, time to do extra—walks, companioning, business and dr. visits. Activation
QUALITY	Continuity of Worker Currently we "never know who's coming in" Time to form relationship with worker. Relaxed Pace	Continuity of Worker Accessible to those not now elibigible or who have trouble accessing. Time to form relationship with worker. Relaxed Pace	Continuity of Worker Relaxed Pace	Continuity
SERVICES	Information DataBase linking clients with those needing work Affordable House-cleaning	Affordable Housecleaning		Database listing housing, home support agencies and freelancers available.

Community Health Workers: a job profile

The Nature of Community Health Work

On any given day, the Community Health Worker will be required to work with clients with some form of dementia (mild to severe), clients who are dying, and clients with varying degrees of physical disability. About half of workers surveyed report working with clients who have auto-immune disease such as HIV/AIDS. There is also some likelihood of being obliged to work in situations involving drug resistant bacteria of various types.

The overwhelming mass of community health work is in personal care. This means that the community health worker helps the client get up from bed, bathe or shower and dress, get ready for their day, and then, later, get ready for bed at night. Much of this work will involve heavy lifts, and single person transfer protocols. A wide range of other tasks can be required of workers as well, including respite care, helping parents with special needs children, assisting with physiotherapy, "task 2" work such as helping with medications, ostomy care and catheter care. For some Community Health Workers housecleaning is also an important part of the work. In our survey of workers, over half the respondents indicated that they do housecleaning as well, as part of the care plan.

Best practices for home support suggest that care should "foster independence" of the client. This means allowing the client to do as much for him or her self as possible. Due to reductions in service hours, workers often find themselves having to rush through the care they provide. Thus, the client is deprived of opportunities for promoting independence—It's just quicker for the worker to put Mrs. Brown's sweater on for her than stand by while she does it herself. Both clients and workers are shortchanged. The client's capacity is gradually undermined, and the worker is stressed by having to provide less than optimal care.

Working conditions vary greatly from home to home. Personality differences, health differences, even income differences can make two identical seeming care plans for giving a bath, in fact be completely different work experiences. Given the varied conditions of homes, equipment and the dynamics of the client's family, the Community Health Worker needs to be very flexible, able to problem solve without supervision and treat each client individually. Some workers note that, due to the isolated nature of the job, Community Health Work is actually more difficult and demanding than it's "Residential Care" counterpart.

The Community Health Worker can be an important monitor of a client's state of health. Daily contact allows a worker to note gradual changes in the client's condition that could otherwise be missed. Unfortunately the current system does not take full advantage of this. Community Health Workers are not formally seen as part of the health care team around a client, and therefore are kept "out of the loop" regarding client health status and planning of care.

In our survey we found that once workers are established in regular positions for more than 3 years, they show a remarkable stability—staying in the same agency for up to 20 years. The largest number of workers surveyed worked 25-30 hours per week. Most of these workers wanted more hours. Of 49 responding, 26 workers listed "helping or making a difference to people" as the thing they liked best about home support as a job. A further 17 said they liked meeting and learning from people. Of 19 "final comments" in the survey, 15 dealt with some aspect of client wellbeing. It is clear that community health workers appear to be motivated by altruism in their choice of career.

Although Community Health Workers receive a training certificate, there is no industry wide set of "declared competencies", no licensing procedure or regulating body governing the sector. This contributes to a low status image for workers in this field.

Jobs in Home Support:

Community Health Worker 1

- "Home Support/ Resident Care Attendant" (H.S.R.C.A.) ticket not required
- duties primarily cleaning
- expected salary--$10/hr

Community Health Worker 2

- "Home Support/ Resident Care Attendant" (H.S.R.C.A.) ticket required
- personal care (toiletting, bathing, shaving, brushing teeth, hair care)
- assisting with dressing
- assisting with transfers from bed to chair, chair to standing
- assisting with walking
- meal preparation*
- company for walks, assistance with shopping, visits to health clinics, etc.*
- expected salary $13 (private) $15.10-$18 (bcgeu)

* Private sector only. The private sector does not differentiate between Community Health worker 1 &2.

Working conditions vary greatly depending on whether one is a unionized regular worker, a unionized casual worker, a non-union worker, or a freelance worker. In the Unionized sector, a newly hired worker usually begins as a Casual worker, providing service to new clients.

Unionized Casual Workers:

- H.S.R.C.A. certification or equivalent required.
- Wage starts at $15.10 per hour
- Usually work a low number of hours per week—20 or less.
- Works 1-3 hr. blocks with each client, often with long breaks between clients.
- Because they have no seniority, casual workers are frequently "bumped" from clients when the agency needs to protect the stability of the hours of a more senior regular worker. (When the client of a regular worker goes into hospital, the agency must find other hours to fill in for that worker—those hours come at the expense of the casual worker) If a casual worker is able to maintain 15-20 hrs/wk over a 3 month period, those hours become "regular" hours and the casual becomes a "regular". Union members note that the key for casual workers is to limit their availability hours to peak times.
- Are not given advance notice of their schedule.
- Show the highest turnover rate within the industry. In constant demand, they are also constantly leaving the sector due to unstable and low numbers of work- hours.

Unionized regular workers:

- Must have H.S.R.C.A. certification or equivalent.
- Earn a good salary, starting at $15.10 per hour.
- Earn seniority based upon their years of service. The more seniority a worker has, the more stable their hours of work are per week.
- Are guaranteed a range of hours per week—15-20, 20-25, 25-30, 30-35, 35-40. Most workers in our survey fell into a range between 25 and 35 hours per week.
- Work 1-3 hr. blocks with each client, often with long breaks between clients.
- Are committed to be available for work over a ten-hour period, known as the 10 hr window. This doesn't mean that they will be paid for ten hours of work—it just means they must be available. Frequently a worker only gets 6 hours of paid work during this time. The 10 hr. window makes for a very long day for workers.
- Receive advance warning of their scheduled hours.

Non-union workers:

- Do not always require certification. Life experience is more likely to count in getting hired.
- Receive lower wages than unionized workers—usually in the $11-$13 range.
- Work 1-3 hr. blocks with each client, often with long breaks between clients.

Freelance Workers:

Anecdote suggests that there is a pool of freelance home support workers who do a full range of tasks. The size of this population, its training, wages or working conditions are unknown.

- Must make their own contacts with clients, through newspapers, notice boards, home-support lists kept by some community agencies, hospitals, etc.
- Must pay their own CPP, EI, Insurance and benefits.
- Can set own wages on a case-by-case basis with clients.
- Can schedule their own time

Values

Continuity of Care:

Affordable Housecleaning

Home Support: Work Access And Infrastructure

Unions

Since the mid 1980's, Public Sector home support has been strongly unionized. Overwhelmingly BCGEU is the largest, but BCNU and UFCW are also involved. Home support agencies in the Public sector are all covered under the same master collective agreement. This agreement:

- Changed the name of position from "Home Support Worker" to "Community Health Worker"
- Has brought community health workers to near wage parity with residential care attendants*
- Workers in theory are guaranteed a set number of hours of work per week. Staff is classified as "regular" or "casual", and workers are locked in to a range of hours per week—15-20, 20-25, 25-30, 30-35, 35-40.
- Commits regular workers to be available for work during a "ten hour window" during which time they can be called and scheduled for work. This provision, intended as a way of protecting workers from split shifts and long days, and ensuring that agencies had a sufficient pool of available workers, is quite controversial as the chart below illustrates.

Stakeholder	Pro	Con
Agencies	The window times can be adjusted to meet worker needs (ie. window from 3am to 1pm) to accommodate someone who only wants to work mornings. Schedulers find life easier with 10 hr. window	Is making it difficult to make job attractive. Hrs. come at the same times of day —tons of workers working small numbers of hours. Staff have difficulty of adapting to 10 window Availability rules make it very difficult to hang on to casual workers. Earlier agreement gave staff more flexibility
Workers	Get more hours of work/see more clients The 10 hr window gives breaks between clients which help us to attend to chores and appointments. Better than having to work 12, 14 or 24 hours like in the "old days"— you know the time you are to be available. You can see one client twice in a day	Makes for a very long day, contributes to burn out. Long breaks between clients in which to do nothing but wait. Having to be available for 10 hours but only getting paid for 4, 6 or 8 isn't fair. Long breaks create split shifts Doesn't leave enough work-hours for those with less seniority. Advantage is to the agency only
Clients		Home support workers are disempowered

- Guarantees scheduling on the basis of seniority. Regular workers and workers with seniority are given preference in scheduling. If the client of a regular worker is hospitalized, the agency is committed to "make up" the lost hours to the regular worker with hours with another client. Usually this means that another worker with less seniority loses hours. It also means that the client's continuity of care is jeopardized. This seniority provision is also controversial, as the chart below indicates

stakeholder	Pro	Con
Agencies	.	Creates more workers going to the same clients, disrupts the clients service. It is very difficult to maintain continuity and stay within collective agreement
Workers	Senior workers get more consistent hours. If a worker is properly trained and professional, the quality of care should not suffer with lack of worker continuity. Workers should be interchangeable—the important consistency is in the quality of the tasks done, not the relationship.	negative effects on clients—they don't necessarily get the most suitable worker not enough hours for casual or more junior workers
Clients		The new collective agreement has adversely affected quality of care because seniority-scheduling has made continuity uncertain. Clients never know who is coming in. "One case I know of had 200 different workers over a 11/2 year period. huge problem is getting and keeping someone who is good. old people definitely need consistency—especially those with cognitive and visual impairment.

Of 50 Community Health Workers surveyed, 34 commented positively on the collective agreement, citing wages and benefits, protection of workers, seniority, job security and parity with facility wages as the main benefits. 27 negative comments about the agreement included specifics of the agreement, negative effects of seniority policies on clients and casual worker, lack of hours for casual workers, lack of flexibility, scheduling, and a lack of concern for worker well-being.

The Employers

Publicly Funded Agencies: a shrinking casual workforce

Within the CRD, there are 7 home support agencies contracted by VIHA to provide home support services over 9 geographical areas. All agencies are unionized—BCGEU, HEU, UFCW.

- **3** are non- profit societies,
- **4** are for-profit companies. **2** of these are franchises for multinational chains.
- Approximately 1,000 community health workers are employed by these agencies.
- Client-Staff ratio is around 3-1 on average.
- Charge for service $29.00/hr. Two agencies bill Housecleaning at $20/hr
- Community Health worker starting salary is $15.10/hr . Two agencies pay housecleaning at a lower rate of $12.10
- For the most part, all staff do all types of work
- About 33% of workers on average are casual workers

Agency	Regular	Casual
A	38% (25-30+hr.) 30%(20+hr.)	32%.(20-35/hr)
B	50%-	50%
C	59%	24%
D	55%	45%
E	75%.	25%
F	75%	25%--

- Regular workers and workers with seniority are given preference in scheduling. Worker hours and seniority may take precedence over client's wishes when it comes to scheduling services. This preference works against the interests of casual workers and the client's need for continuity of worker.
- Demands for service fluctuate as clients come and go. Fluctuations cannot be predicted and so agencies find it hard to plan for recruiting and hiring. Retention of casual workers is adversely affected.
- Most agencies report a shrinking payroll over the past few years, which they attribute to the reduction of client hours due to redefinition of client eligibility rules , and the scheduling demands of the collective agreement. Turnover is commonly between 8% and 10% of regular workers. Turnover of casual workers is much higher—50% at some agencies. One manager observed that "casuals leave—people who have been in 2-3 years stay" The main reasons for this is that, due to union seniority rules, casual workers cannot get enough hours. Union members suggest that part of the difficulty lies in casual workers not limiting their availability to peak hours.
- Recruitment: Recruiting patterns vary greatly between agencies. Some report recruiting "constantly" or every six weeks, others report recruiting annually or only on an "as needed" basis. Recruiting is usually for casual staff or live in staff only. Recruiting procedures usually involve news ads, word of mouth, posting requirements at Camosun or the University, going through dropped off resumes. One agency recruited by providing their own training (see Training)
- Qualifications Required: All staff must have the HSRCA certificate or equivalent.(Care Aide, Old Home Support, LPN, Care Aide, Old Home Support, LPN) There are only a handful of non-certificated staff. These are employees of very long standing, grandfathered from before union agreements. The single exception to this is in the Gulf Islands, where, on the smaller islands untrained people may be hired based on life skills and personality with potential to be trained. One agency has designed a test for those without up to date certificates.

- Additional qualifications required: criminal record, bonding, TB check, references, experience,1st aid, Foodsafe, proven ability to communicate well (written and verbal) demonstrated ability to work without supervision, genuine desire to work well with people, flexibility.
- In service Training Some agencies provide initial on site training, such as a one day orientation. Most agencies provide some type of in-service training.

Each agency has a distinct client constituency determined by the locale they serve. For example, one agency in the downtown core serves many more mental health and family in crisis clients than other agencies.

Agencies in rural areas have greater transportation time problems, and greater difficulty in attracting and retaining workers—particularly in remote areas such as the Gulf Islands.

Agency managers listed the following as "greatest challenges" in general.
- Uncertainty— it is difficult to budget and staff.a service with no waiting list, and a fluctuating demand as well as trying to provide a standard of care under funding restrictions, while costs escalate.
- Agencies have responsibility but no power or control in the system. This makes juggling the needs of frailer clients and unionized workers difficult.

Greatest challenges in terms of staffing were listed as follows.
- An ageing workforce--50% are between 45 and 55. Going to be difficult to get trained people.
- Fluctuating need, combined with inflexibility of collective agreement around scheduling. More flexibility would help with worker retention and continuity of care.
- Lack of guaranteed hours for casual staff makes it difficult to get and retain trained staff when you need them.
- Differences in funding from one Ministry to another can make it difficult to find live in staff.

Staffing goals for the near and medium term were listed as follows:
- maintain as much continuity of care as possible
- to reduce turnover, schedulebest trained senior workers . Important for people to be satisfied with work
- replace retiring people
- educational sessions, more in services and upgrades, to make certain that there is adequate staffing to deal with holidays and meet needs of agency .more supervisors one on one with workers, in services.

Projected Employers: Publicly Funded Supportive Living

The goal of the supportive living model is to fill the gap between home and facility; providing housing in which expandable, flexible home support and different levels of care are built-in. It is alternative housing, not a care setting. Clients will be individuals dealing with isolation who need a range of services, including meals, cleaning and activation, andwho cannot afford to live in a private congregate care situation.

Social involvement of elderly is very important. The Home Support Worker needs to be a support so that the client can be involved in the community, in social activities—the coming of the home support worker itself should not be the extent of the client's social life.

In the literature Assisted Living is defined as "having on site care staff"—VIHA's approach is more flexible because there is already an infrastructure for Home Support. The care is contracted out to a home support agency and the agency does the scheduling. Continuity of care is assured. Unions have indicated a

willingness to work with this model. Early projects will use existing home support infrastructure, later ones may have on-site care. (same type of worker, different employer). A projected 600-700 units over 3-5 years are planned including purpose-built stand-alone complexes and existing apartments.

VIHA is currently running pilots in two purpose built residences.

Luther Court:

- At present, 14 apartment units out of 68 are receiving home support in a cluster-care model—number will change over time, as more residents require assistance—up to 20. Service includes expanded supports such as meals, personal care etc.
- A primary worker is there all day functioning as an on site co-ordinator. This multi-tasked worker facilitates activities and group meals as well as personal care, and needs a broad skill range including—time management, activation, ability to work to promote independence to maintain client's ability and involvement in the community.
- These positions are currently paid at an hourly rate, but could easily become salaried.

St. Francis Manor by the Sea

- A stand alone complex—12 clients share meals and common areas, have independent rooms.
- There are 2 primary day- time home support positions Monday to Friday, and weekend workers—a total of 4-5 workers.

VIHA is also running a pilot to explore the utility of cluster care in existing apartments through the James Bay Community Project Supportive Living Pilot

- This pilot includes a mix of programs to provide safety, opportunities to socialize, meals and housekeeping/home support in existing housing stock
- Home support component will consist of cluster care in high density apartment buildings and neighborhoods.

The Employers: C.S.I.L. Publicly Funded Adults with Disabilities

A small part of the Public sector for Home Support is the C.S.I.L. program (Community Supports for Independent Living). Under this program, clients eligible for home support (usually adults with disabilities) receive a lump sum payment from the Ministry of Health and contract for their own home support services. After establishing a business committee of 5 to assist them, they hire, train, pay and fire their home support workers privately. In some cases these arrangements contravene the labour code—for example, by requiring the worker to work for only 1 hour at a time. Also, as wages are decided by the client, workers may work more hours for less money per hour than elsewhere in the public sector.

Projected Employers: Publicly Funded Personal Assistance Cooperative Society

The Personal Assistance Cooperative Society, a consumer co-op, is in the developing stages. Members of this Co-op will be VIHA clients who would normally be on the C.S.I.L. program.
workers will be employees, but not members of the co-op. PACS has received a small amount of funding to set up a pilot program in January 2002.

- The Coop will consist of several "pods" of 6 or 9 clients. Three clients will share a worker and function as a hiring group. The workers will be familiar with the care plans of 2 or 3 clients in addition to the 3 they usually serve. This will ensure that clients have consistency of care in case of worker illness.
- The clients in each pod will have a mix of needs—different hours, different care plans, to help ensure that workers will get enough hours.

- PACS will guarantee worker hours, and medical and dental benefits, and will provide in-service training into the subtleties of personal assistance
- Workers must have Home-Support / Residential Care Attendant tickets.
- PACS hopes to offer services for a financially competitive fee.

Private Agencies: a stable part time workforce

Within the CRD there are 8 private home support agencies of various sizes, employing approximately 300 people. Some of these agencies are affiliated with residential care homes. These agencies, paid directly by clients, are not bound by VIHA restrictions. Accordingly, they provide a broader range of services beyond personal care—including: house-cleaning, shopping assistance, walks, errands, companionship, appointments, advocacy when families are out of town, moving, consultation with other professionals, transport , respite care, and other tasks that the public sector agencies are not permitted to do. In some cases, these private agencies work in concert with public agencies to provide additional services to subsidized clients. These agencies are mostly non-union workplaces, with the exception of one that is organized by the Christian Labour Association.

- Of the four private agencies surveyed, all showed a slightly higher ratio of workers to clients—1:2 in one case.
- Fees range from $ 18.50 to $22 per hour. Fees for service at three of these agencies are on a sliding scale, with housecleaning costing less per hour than personal care. (Lowest fees mentioned were $18.25/hr for companion services.)
- At some agencies, home support workers are paid according to a scale of wages, depending on the work being done. For example, cleaning is paid at $10/hr, while personal care work receives $12/hr. At other agencies all work receives the same hourly rate
- Lower pay than public sector agencies—.($11-$13.50/ hr.)
- Workers for these agencies mostly work part-time.

Agency	Workers	Fulltime	Parttime
G	12	6 ft(35+hrs. wk)	4pt(15hrs. wk)
H	20	4 fulltime,	16 part time
I	35	none ft—	all pt.—
J	5	none	all casual.

- In contrast to managers of Public agencies, 3 of the four Private agency managers surveyed felt their payroll was staying the same over time, and one anticipated growth. Managers reported staff turn-over rates as very low. A typical comment was "we lost someone last year". Some of the explanations for low turn over include:
  - (our workers have a) different outlook. They are screened and not in it for money,
  - People stay a long time. Have had staff for 6-7 years. They are remarkable people—really committed. Workers tell me what they want, I try to give it to them.
  - They leave (to work at Public agencies) and come back because of seniority issues. They get shitty shifts
- Recruitment styles vary, with some agencies "never" recuiting, and some recruiting throughout the year. Several agencies stressed that the matching of worker to client is critical.
- Qualifications Required: A Home Support/Resident Care Attendant Ticket is not always required, although 3 of the 4 agency managers surveyed mentioned it as a requirement.
- Other Requirements and qualifications include TB check 1st aid, criminal record check doctor ok – re lifting, life skills, instinctive basics compassion, ethics, ability to learn, other courses, palliative care, cancer regime, dementia,

- In Service Training: In service training is often client specific—when hired, a worker is accompanied to site, familiarized with a buddy first couple of times. A second agency provides "introductions" of worker to client.
- One of the agencies (connected with a residence) contacted provides regular in services, One encourages staff to take courses, one provides one on one client- specific briefings, one agency trains staff around the care-plan, and updates, regulates that way.

Managers report the biggest challenges generally revolve around employee issues. (late, communication, time wasted, Scheduling).

Biggest challenge in terms of staffing:

- Trying to find right qualifications: Such a mixed bag of courses—hard to keep up which ones are good and which ones aren't. Real range in what programs turn out.
- Providing a fair wage.
- To get good caregivers that really care for the client.
- To get good client/worker matches; try to keep continuity.

Mangers report staffing goals for staffing in the near term and medium term are basically to maintain and increase staff.

Training in Home Support

Work Seekers

All publicly funded Home Support Agencies require their staff to have received formal training. In B.C., that training is provided through the Home Support/Resident Care Attendant program. This is a dual certificate, allowing a person to work either as a Community Health Worker, or as a Resident Care. Across BC, there is a wide latitude among training programs.

A student completes the Home Support portion first and can either stay to complete the Resident Care portion, or leave to work as a Community Health Worker without the Resident Care part of the certification. The complete program readies students to work primarily with frail elderly in either the home or residence setting. The course includes Personal care, peri care, bathing, transfers, meal preparation, shopping, weeks menu, palliative and Altzheimer's/ dementia. There is some focus on people with disabilities but it is not the prime focus. Emergency situations—providing emergency treatment till help arrives—is also covered. It is interesting to note that the curriculum assumes that less training is required for what many believe to be the more demanding job.

Many training programs have difficulty providing adequate Home Support practicum placements to students.

This is a provincially created curriculum adapted and taught by 2 educational institutions in the CRD—Sprott Shaw and Camosun College. Also, some years ago, one agency did collaborate with HRDC to conduct one training session in a successful effort to acquire staff.

Sprott Shaw

- Cost $ 7460.00
- Entrance requirements –gr. 12 or GED, or mature student status.
- Program is 7 months long (4 months theory, 2 ½ months practicum, 1 month intermediate care, 1 month extended care, 2 weeks home support)

- An annual total of 60-80 students are trained in 3 or 4 intakes per year, 20 students per intake
- Advisors pre-screen participants, do verbal, math and communication tests.
- Most students are hired into home support at training's end (until they can get into facilities.)

Camosun's program

- Cost $1152.00 including ancillary fees (likely to increase)
- Entrance requirements – gr. 10.
- Currently runs 23 wks.
- 152 full time students are trained annually in three intakes—2 are for a regular program, and a third is for ESL students. Enrollment is approx. 64 full time and 12 part time students per intake for regular, (128 FT , 24 PT annually) 24 students in the ESL program..
- A program for First Nations students has run, is awaiting funding before running again. It is slightly longer, has more built in supports for students.
- 24 Part time study seats are available. If taking the whole course, it takes 1 year to complete part time. Most part-time students in this program are people with the Home Support ticket who wish to upgrade to Resident Care Attendant.
- Program is primarily targetted toward the care of elderly people.
- Students are on average mature (28+), usually have had other work experience (fishers, loggers, waiters, BAs) some have done personal care for relatives, or were working in the field without certification.
- Camosun has no screening process. Enrollment is first come first served, provided you meet entrance requirements. Attendance at information session is encouraged, but not required. Information session discusses the home support worker's role, pay, and expectations. Staff tries to help students self-select.
- There may be a short wait list, but "waited" students will be accommodated by the next intake.

Training by Agencies

Home Support is "certified" work, but not a licensed profession, so no governing body regulates it at present. For this reason, it is possible for Agencies to provide their own training by purchasing the published provincial curriculum from an educational institution, and hiring a qualified professional to teach. Trainees in this model must be eligible for work-place based training credits through E.I. or Income Assistance, and must be guaranteed a position after training has been successfully completed. They do not receive the certification that they would receive through an educational institution, but obtain equivalency through their agency.

One agency did this in order to recruit workers. They did 2 intakes, one for EI, the other for Income Assistance. There were 14-15 each intake. JobWave did prescreen, the agency bought the provincial curriculum from Camosun and HRDC. provided training funds. EI group was 100% successful, and were all hired. 9 continue to be employed. In the IA group 3 did not complete the course and 20% were not successfully hired (didn't stay)

Other Agency Run Training

Agencies can build other courses that are appropriate to their clientele. One agency with a high mental health and family in crisis clientele created their own 8-10 week mental health course. Workers received a certificate on completion. The same agency also purchased a court orientation course, to be taught by a lawyer.

Training of Workers

Continuing education of workers is uneven and inconsistent. Because workers are "time poor" it is difficult tfor them to take time off work to learn new skills or brush up on existing ones.

In-Services

In service training is a very important tool for raising and maintaining skill levels for Community Health Workers, especially with the growing complexity of client needs.. Most publicly funded Home Support Agencies hold in-services monthly or semi-monthly. It is generally acknowledged that turnout tends to be low because attendance is neither paid nor mandatory. One Home Support Agency recognizes attendance at in-services by awarding "seniority hours" to workers who attend.

Most agencies have seen their budgets for in-service training decline over the past few years.

Further Training/Upgrading

Some publicly funded agencies help workers get further training. Two agencies will pay tuition outright but not study time. One agency will pay half of tuition, another agency will help the worker to arrange training. In additon, one agency has supervisors do onsite evaluations. If further training is needed, on hand demos will be held, and the agency pays extra fees.

Market Opportunity

According to VIHA's most recent planning document (name?), the population in the Capital Health Region is expected to increase by approximately 15% from 335,000 to 385,000 between now and 2015. The largest percentage growth will be in the 55 to 69 year age group. The elderly population (85+ years) will continue to grow over the next ten years. The table below shows the percentages each age group is expected to make up of the general population over time.

CHR Population by Age Group

	0-19	20-44	45-64	65-74	75-84	85 and older
1997	22%	37%	23%	9%	7%	2%
2015	18%	30%	31%	12%	6%	3%

These figures suggest that Home Support should be a growing sector, as more and more people grow to the age at which such supports and assistance are commonly needed. Unfortunately costs associated with home care and home support, while lower than acute and residential care, are still quite high, resulting in a far slower growth of services than one would expect.

Never the less, opportunities do exist in niches within the sector

- **Affordable House Cleaning (CHW 1s):** Client/client family data indicates that a number of clients who are in need of service, but not now receiving it, would be willing to pay a small sum ($10-$15 per hour) to receive it. Currently only freelancers provide those rates.
- **Supportive Living:** Community Groups, co-ops and others could partner with builders and other sectors to create many supportive living situations.
- **Web-Accessible Information Bank** : data on housing and home support services (workers and agencies) available. Information available for a finders fee.
- **Home Support Training:** Educators could expand existing courser, and design and provide Regular Refresher Courses. Educators could also partner with agencies to design and co-ordinate "all agency" in service training.
- **An Educational Resource Databank** could provide information about educational resource sharing, information on programs/courses available in the community.

Sector Assets

- Large number of public and private home support agencies with experience
- CSIL program and other planned innovative public programs (Supportive housing)
- 2 training facilities
- Large number of community organizations to assess needs and guide development of innovative projects
- Suitability of basic aspects of home support as entry level jobs (Community Health Worker 1) and as work in which personal interest, gentleness and supportive attitude are more important than academic qualifications or advanced English Language skills.

Employment Outlook

Employment opportunities at present in the public sector as it is currently structured appear to be shrinking, as funding for subsidized home support shrinks.

New employment is likely to be casual or regular part time work, at least for the first 2-3 years of employment.

As more of 600 supportive living units come on-stream, there will be more opportunities for employment as primary workers in purpose build accomodations and high density buildings and neighborhoods..

Opportunities in the private sector are uncertain although some private agencies appear to be expanding slightly. Working conditions in the private sector are unregulated and wages are low.

The development of new programs and services, such as Affordable Housecleaning,could increase employment opportunities.

Gaps in the Sector

Skills Gaps

- Worker skills can lapse over time., workers can get stuck in old practices.
- Increasingly complex care needs of clients.

Training Gaps

Of Work Seekers

- **H.S.R.C.A.course is taught in such a way as to make the Home Support industry the "black hole", people are discouraged from working in it"**

- **Affordable Certificate Training :low number (24 per year) of part time seats for HSRCA training.**

People who want to work at another job while taking the training part time, may be prevented by the relatively low number of part time seats available.

- **Training for cleaning standards as per "home management" module in HSRCA program.**
  The assumption that "everybody knows how to clean" is not accurate.
  If one planned to work as a freelance cleaner, or as part of a cleaning network, it would be important to have certain training. Proper use of cleaning products, and the best for low toxicity/low fuming (important for people with compromised immune systems is one area of training required. Cleaning techniques, efficiency, putting things back in the right place, all require practice.

- **Broader Range of Topics** Other subjects desired for curriculum by agency managers and clients include: course for workers providing care in assisted living situations, live in, palliative, social issues, family dynamics, brain injury, heavy lifts, and specific illnessness such as Parkinson's and MS.

- **Client experience is missing from HSRCA program.**
  HSRCA program is not based on "how it is" for the client. It trains workers for the agency, not the client. It gives a baseline competency, but the client experience is missing. Problems are situation/person specific. The training gives "what works generally" , but doesn't delve into the individuality of the client

- **Inadequate peripheral training such as palliative and dementia** Client Community Group Directors felt that this training is inadequate and "hit and miss" One respondent who gives in-service training felt that students seem overwhelmed, that too much is being covered too quickly.

Of employed workers

- **Workers should be trained in Nursing Task 2 Tasks:** Community Health Workers are not allowed to perform so called "task 2" or nursing, tasks, such as giving medications, yet for convenience sake it often makes sense that they be allowed to do them. An Agency is forced to go through a cumbersome and expensive process to clear a worker to perform task 2—s/he must be specially trained in the tasks, by a public health nurse, on a case by case basis. Even if the worker is currently performing

task 2 tasks with another client, s/he must still be trained for each new client requiring that level of tasks. This system is not only costly in terms of time and money, but it is insulting in its assumption of lack of worker competence.

Agency managers and workers alike suggest that something should be done about the "task 2 gap", whether that be in-service group training of workers, or the addition of task 2 protocols to the HSRCA training. 5 of 9 managers said that home support training needed to be upgraded to include "task 2" or nursing tasks. Of these 3 felt that current Home Support training had "gone as far as it can" and that Community Health Workers should be retrained and upgraded to LPN status. This would simplify the administration of providing complex care in the home.

- **Workers are "time poor" and cannot afford to take time off work to study:** Possession of an H.S.R.C.A. ticket does not mark the pinnacle of training for a Community Health Worker. It is to the advantage of workers, agencies and clients for workers to pursue on-going training, and further specialties.

Community Health Workers are "time poor", and taking additional training could put them into situations of financial hardship
Of the 50 community health workers surveyed,

- 39 indicated they would like to take further training.
- 24 indicated that they would take more training if they could be paid for their study time.
- 27 said they would take further training if their agency would contribute to the cost of fees.
- 11 indicated they would like to upgrade to LPN status,
- 4 indicated they would like to train as RNs.
- Many other types of training were requested as well including ongoing upgrades for Foodsafe and 1st Aid, Training in Dementia and Palliative Care, Activity Aide training, physiotherapy, medications, massage and more.

Support Gaps

Client needs not being met:

- **Continuity of Service:** Because Union seniority rules allow bumping of more junior workers to protect the hours of more senior workers, client well being is jeopardized. Continuity of service, having the opportunity to establish a relationship with the community health worker is extremely important to clients—especially where intimate care such as bathing and catheter care is being done. Clients note that currently they "never know who is coming in." Anecdote tells of many clients who cancelled service due to the disruption of lack of continuity.

  For the client to stay as independent and vital as possible, it is important that home support be conducted at a slow enough pace to allow the client to do as much for themselves as possible.

- **Portability:** While the term portability usually means transferable from one jurisdiction to another, it can also be used to mean "including accompaniment to the larger community beyond the home. Many clients, especially younger adults with physical disabilities, require a continuum of services which provide physical assistance with everyday living. This can involve personal care attendant, homemaking, and much between.

- **Affordable housecleaning** 100% of those clients surveyed who feel they need more home support report needing housekeeping services such as vacuuming, laundry, cleaning refrigerators and stoves, kitchens and bathrooms. Many directors of client centered community groups noted that housecleaning is not a

frill, but a necessary tool to maintaining health. As one respondent noted " a client can be beautifully groomed to go out and live in filthy surroundings".

Agency managers reported that they felt that clients would aloso want additional services such as yard work, home maintenance, respite, transportation, handyman, assistance business to dr. appt., time to do extra—walks, companioning and activation.

- **Affordable Meal Preparation** People are encouraged by VIHA to use Meals on Wheels. This is expensive. Many MS clients are only on disability 1 and cannot afford M. on W. or private home support. ($20-29/hr.) Many clients have tremor which makes standing to cook impossible.
- **Access To Information About Available Freelance Workers:** Clients who do not qualify for subsidized home support face substantial difficulty in finding alternate service providers. Several organizations have partial lists of available workers, but these are not screened. Vulnerable clients, facing this daunting task alone, may choose not to look for help, to their detriment. Other clients risk being taken advantage of by the unscrupulous.
- **Control/choice of care**

Workers

- Lack of regulated staus with declared compenties.
- **Community Health Workers working in unsafe situations doing single heavy lifts, etc.**

Communication Gaps

- **Among Workers Who Share A Client** While several workers may "share" a client, their only communication with each other is often the "communication-book" kept at the client's home. Workers have no opportunity to share face-to-face experiences, perceptions and techniques with each other.
- **Between Community Health Workers (Hsws) And Others In The Health Care Team—Dr., Home Care Nurse**. Workers see the client more often than any other member of the health care team, and are highly aware of the client's condition over time. Their observations could be extremely useful in the planning of client care but there is no mechanism for them to be included in the team.

Awareness Gaps

- **Attitudes About Home Support And Community Health Workers**: A lot of assumptions are made about home support as a career—that it's low status, low pay, "women's work". Because much of it revolves around the home, it is work that generally goes unpaid and unaccounted for, until a crisis prevents it being done. Then it often carries a stigma. Community Health Workers report feeling unvalued (Macdonald). They are not considered to be part of the Health Care team around a client, and their observations are ignored.
  More.....
- **Attitudes About Clients**.
  The health care system of which home support is a part still ascribes to both the "charity" and "medical" models. (Bowman 2000) These models assume incapacity and impairment on the part of the client, who is seen as a "passive recipient" who needs "fixing" rather than an active member of a work team. (the work being having a bath) This allows the work of home support to degenerate into a series of tasks to be accomplished in a set time—the client becomes an impediment to getting the task done.

Barriers to Employment

- **Hi Incidence Of Part-Time/Casual Positions, Low Number Of Paid Hours**.

  If one has the certification, it is relatively easy to get a job in home support. Agencies hire frequently. Getting enough hours to make a living wage, and keeping those hours long enough to develop seniority, is the problem.

  Few community health workers start out as regular workers. Due to fluctuating client load, most agencies either hire casual workers to fill in with "new clients", or regular workers with small numbers of hours. Seniority rules in the collective agreement work against both these types of workers, through the process of "bumping". The situation is actually worse for junior regular workers in the 20/hrs per week category. These people must not take any other work during their "ten hour window", but may not be getting enough hours to pay the bills. Many of these workers are unable to make ends meet, and leave the industry.

  This issue has huge ramifications for clients, as well as workers. For example, anecdote suggests that on Saltspring, only regular workers are getting hours, because of bumping. The situation is severe enough that new clients are being encouraged to enter facilities.

Needs in the Sector

Training Needs

Of Work Seekers

- **Affordable Training: More Agency Directed Training Programs** Although the Camosun HSRCA program costs just over $1000, this may not be affordable to some. Recipients of Income Assistance may not acquire student loans, and may be ineligible for training credits in such an academic setting. However, partnering with HRDC , the provincial government, and educational institutions (purchase of curriculum) agencies can provide such training themselves. This approach would not only bring economically marginal people into employment, but it would also help agencies to cushion themselves from fluctuations in client load.
- **Increased Number of Part time Seats:** This would make HSRCA training more accessible to those non-certified community health workers wishing to better their situation. It would also allow people with "McJobs" an opportunity to acquire training.
- **Adequate Practicum Placement:**
- **Housecleaning Training:**

Of Workers

It is in the interests of Agencies, Clients and workers themselves that staff development be widely available. This should include:

- **Refresher Courses:** required every two years, study time paid or partially paid by agencies (workers shouldn't be penalized by losing work hours in order to keep current)
- **Existing Workshops and Courses in the Community:** There are many courses and workshops of value to Community Health Workers on-going in the wider community. Some of these carry certification and some do not. Their existence is not widely known. Coordination of information about such events would be beneficial to all. (This could be paired with a general home support information database available to clients)

- **Shared In Services:** While most agencies offer some form of in-service training, they report low attendance numbers. Also, agency budgets for training have been shrinking in recent years. It would make sense for agencies to collaborate on In-service training, by sharing costs and resource people. The training achieved through this collaboration is likely to be of higher quality. It is also likely to be able to be scheduled over a wider range of times so as to be convenient to more workers.
- **Agency sharing of training costs**: While some agencies do share some training costs with workers for skill upgrading training, it may be wise for them to examine ways of doing this more consistently.

Of Clients

- **Consumer "boss" training:** A sizable minority of respondents to our client survey (insert #) reported feeling "taken advantage of" by their community health worker. In addition, the "lazy worker" situation discussed earlier in this paper is a real issue for some clients. Add to this the reality that HSRCA training cannot adequately include the client experience, and you have compelling reasons for the development of a "boss course"—training for clients in how to train and supervise their community health workers. Such training has been widely developed in Europe and the U.S. (Bowman, 2000) This training would also be useful to workers, as an aide to separating the individual from the tasks attached to the individual.

Infrastructure Needs: Workers

- **Funding Mechanism:** Change from "hourly task" model with funds attached to client, to a "block funding" model with funds attached to agency. This would ensure that workers work on a "caseload" basis with clients, rather than an hourly task model. This would increase continuity for worker and clients, and be a better guarantor of hours than the current system.
- **Worker Safety:** Equipment funding from msp needed for home modifications, lifts etc

- **To Increase Communication:** The Community Health Worker must be seen as a valuable part of the Health Care Team. While attendance at case meetings might be impractical, scheduling the client visits of Nursing Supervisors and Case managers to coincide with the presence of workers would ensure a positive flow of information

  In a complex household, where many workers "share" a client, one worker should be designated the "co-ordinator" to facilitate communication and organization.

- **To bridge the "Hi Incidence Of Part-Time/Casual Positions, Low Number Of Paid Hours. gap**: Casual Workers need to be able to be on call to more than one agency. Although this has been raised in the past and rejected because of massive logistical issues, it would not be impossible to compile a casual worker's database that all agencies could use. Such a database would need to be keyed to limit calles outside a certain distance from the workers' home.
- **Changes to method of realizing the scheduling preference to workers with seniority.** Possibly institute a "lag time" so that all parties have time and support while dealing with change. Example. "Mrs. Brown goes into hospital. Instead of Mrs. Brown losing contact with her senior worker, and the worker bumping another more junior worker, resulting in another client losing continuity and stability, institute "lag time" which would provide Mrs. Browns worker with her regular hours to spend with Mrs. Brown for a period (5 days?). While the workers tasks would change, the worker could be an invaluable assett in helping Mrs. Brown adjust to hospital routine, in helping her get to know her new

  care-givers and in helping the hospital staff get to know Mrs. Brown as a person. The worker could also spend that time connecting with Mrs. Brown's family or neighbors, as appropriate, to help them help Mrs. Brown in her changing situation. During the "lag time" the agency has time to find a replacement for the

Mrs. Brown hours—if she is indeed truly off the client list, in a more gradual way. If "bumping" ends up being the only solution, then at least with "lag time" the transition could be managed differently allowing the "bumped" worker to introduce the senior worker, and help to maintain continuity.

Infrastructure Needs: Clients

- **Home Support Information Database:** Client Centered Community Groups and agency managers in focus group identified the need for a web-accessible information bank with data on housing and home support services and freelance workers available. To this roster could be added ongoing training programs and workshops of interest to workers in the community. This roster of items could also be divided among stakeholders. All discussions boiled down to "who co-ordinates", who could take responsibility. There are many options:
  - an individual entrepreneur or group of entrepreneurs could set up such a database and information service as a stand alone resource. Clients, agencies and others wishing to access information would do so on a fee for service basis. This could be organized as either a traditional business or as a co-operative.
  - an agency or group of agencies could add this service to their existing services.
  - existing community groups could add this service to their existing services.

- **Affordable House Cleaning:** Such a service, charging no more than $15/hr. (preferably on a sliding scale according to ability to pay) would be invaluable to the community. In order to be cost effective, this would have to be a low-overhead business, especially in initial stages—perhaps sharing physical space (enough for phone and computer) with an existing agency or community organization. Such an entity could grow naturally out of the Home Support Information Database described above. E.I. and I.A. recipients could receive basic "Home Management" training and quickly be employed. Workers could be connected with additional training for those wishing to become certified Community Health Workers.

Infrastructure Needs: Worker/Multistakeholder Co-op

Creation of a database and cleaning service might well be the initial steps to the development of a worker /multi-stakeholder Home Support Cooperative. This writer favours a multi-stakeholder co-operative because of the nature of home support tasks—the needs and experience of the worker should not be pitted against those of the client. Even family members could become co-op members. (possibly members of the community at large who anticipate requiring home support services in the future could be members as well)

There is a wealth of information about the development of such co-operatives, from the experience of the 20+year old CHCA in the Bronx, NY, to some 50 health care cooperatives in Quebec.

Initial development of such a co-operative would entail the coming together of interested Community Health Workers and Clients, with a Coop facilitator to discuss cooperative principles, shared values and needs.

Among things to consider would be the setting up of a foundation to allow service to client-members suffering financial difficulty.

As members, workers and clients are each guaranteed certain benefits:
worker benefits:
- workers share price could be "worked off" over first year of employment
- regular hours
- good wages and benefits

- "team" model—worker inputs to the team as a matter of course
- cooperative run training
- ongoing staff development program including subsidized training and worker mentors/ worker teachers
- continuity of clientele if desired

client benefits:

- payment of fee for service on a sliding scale based on ability to pay
- case management services
- continuum of services—as a person's needs change, services grow and adapt
- consistency of worker.
- RESPECT, CHOICE, CONTROL,FLEXIBILITY

community members

- share price could be used to build fund to subsidize poorer client members
- annual fees could be payed which, while community member does not need service for self would go to subsidize poorer members. when the community member becomes a client member, s/he recieves initial services at low cost to the value of fees paid.

The co-op would not be dependent on any one source of funding. Income could obtained through fee-for-service payments by individuals privately, through a CSIL or other program, through Ministry of Family and Children, the Ministry of Health, Veteran Affairs or any other body.

Financing & Capital Needs

Pilot salaried community health workers instead of hourly waged ones.

Capital Funding so that new agencies/ coops can cover client-load fluctuations

"Home Support Insurance"

Communication & Coordination Needs

- **How do you attract the right people to this industry**? Start in the school systems, providing info about the field. Find positive ways of attracting people to the work, making opportunities.

- **"Team" Approach To Case Management:** Agencies, Coops and LTC set up a so that the knowledge and perceptions of workers are not missed, and to ensure continuity of care plan etc. This team includes Nurse Supervisor, LTC Case Manager, Community Nurse, all of a client's workers .

Research Objectives

The purpose of this research was to:

- Explore and characterize market demand, skills required, and current training opportunities in the local Home Support Sector
- Identify gaps and needs in infrastructure, workforce training, preparation, or awareness, obstacles to working in the sector, and infrastructure needed to facilitate work in the sector.
- Propose potential solutions for implementation by community stakeholders

One of the main assumptions in this research is that market demand for home support services lies is dictated in part by existing employers in the sector and in part by potential employers, including clients and client families.

Research Approach Constraints. Sector Research Advisory Committee

The research involved both primary and secondary research. An annotated bibliography of the latter is appended to this report.

Primary research involved formal interviews with staff from client-centered community groups, managers of home support agencies, project managers within the Capital Health Region and home support workers. Some interviews were in person, and some face to face, but all followed the same schedules, appended to this report.

Both home support workers and clients/client families were surveyed.

200 Surveys were distributed to community health workers in 5 agencies. The survey covered two main areas:

- Type of Work. This section asked about length of service as well as hours worked per week and tasks done.
- Training. This section asked about current certification levels and needs/desires for further training.
- Several open-ended questions were asked as well. A copy of the survey tool is in appended to the report as is a "Community Health Worker Report"

50 surveys were returned—a return of 25%. 48 of the surveys are from workers employed in the public sector.

330 surveys were distributed to clients and their families through community groups. 51 surveys were returned—a return of about 15%. The surveys explored two areas:

- Type of Service: This section attempted to discover what type of home support service the clients were currently receiving, whether the clients felt they needed more service, and what areas they required help in
- Quality of Care: Explored the nature of the client-worker relationship, and what, from the client's point of view was most important