

Personal Support Homes: An Innovative Approach to Reduce the Alternative Level of Care Population in Ontario Hospitals

Foyers de soins personnels : une approche novatrice pour réduire la population d'autres niveaux de soins dans les hôpitaux ontariens



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Abstract

Objective: This study investigates the viability of personal support homes – a policy concept that reduces alternative level of care (ALC) days in Ontario hospitals. It allows people to leverage their empty bedrooms to temporarily house patients awaiting hospital discharge.

Method: Data from the Municipal Property Assessment Corporation are used to map geographic supply of empty bedrooms, and Ontario Ministry of Health administrative data are used to assess potential demand.

Results: By remunerating certified homeowners \$120–150/day, this concept could help decrease ALC patient days by 20% and save the province \$1.13–1.95 billion in foregone hospital construction along with relieving current system pressures.

Conclusion: As part of a multifaceted policy solution to ALC, this concept is particularly suited for rural/remote locations where excess bedroom supply per capita is the highest.

Résumé

Objectif : Cette étude examine la viabilité des foyers de soins personnels – un concept de politique qui vise à réduire les jours d'autres niveaux de soins (ANS) dans les hôpitaux ontariens. Il permet de tirer parti des chambres vacantes pour héberger temporairement des patients en attente d'une sortie de l'hôpital.

Méthode : Les données de la Société d'évaluation foncière des municipalités ont été utilisées pour cartographier l'offre de chambres vacantes alors que les données administratives du ministère de la Santé de l'Ontario ont été utilisées pour évaluer la demande potentielle.

Résultats : En rémunérant les propriétaires certifiés de 120 à 150 \$/jour, le concept pourrait réduire les jours-patients ANS de 20 % et économiser à la province de 1,13 à 1,95 milliard de dollars en constructions d'hôpitaux, tout en soulageant les pressions actuelles sur le système.

Conclusion : Dans le cadre d'une solution politique multidimensionnelle à l'ANS, ce concept est particulièrement adapté aux régions rurales et éloignées où l'offre excédentaire de chambres par habitant est plus élevé.

Introduction

A white paper from 2007 first identified optimizing patient throughput as a key operations strategy to ensure future supply of hospital services (The Chartis Group 2007). Efficient flow through a hospital's fixed bed supply, diagnostic and imaging centres and procedure rooms allows hospitals to focus on taking care of acute care patients rather than on discharging the backlog. This has become an evermore critical issue with the baby boomer generation imminently turning 75 years old when there is a noted increase in demand for hospital services (CIHI 2019). Furthermore, the percentage of the Ontario population that is older than 75 years is expected to be 20.3% by 2031 (Ontario Ministry of Finance 2019). Hospital volumes in Ontario dramatically decreased during the COVID-19 pandemic due to cancellation of elective surgeries to ensure surge capacity (Government of Ontario 2020). As the second wave of the virus emerged in the fall of 2020, and the third wave in the spring of 2021, hospital volumes continued to fluctuate; however, the issue of hospital overcrowding will likely re-emerge as common elective surgeries such as hip and knee replacements resume fully (OHA 2020).

In Canada, throughput issues in hospitals have focussed on two critical areas: 1) the emergency department where patients are waiting to be admitted and 2) discharge when patients – particularly older, frail patients – cannot be discharged without support. As a result, emergency department patients are waiting to be admitted or are occupying a bed beyond clinical necessity (Sutherland and Crump 2013). The second of these two sets of patients are designated as alternate level of care (ALC) patients – a term used to describe patients who do not necessarily require the acuity of hospital service delivery (CIHI 2016). These two critical areas are only somewhat interrelated as many beds occupied by ALC patients – for example, surgical recovery beds – are not necessarily the same hospital beds needed for admission directly from the emergency department. Hence, both these issues require somewhat separate solutions. This paper will focus on the second (ALC) issue, offering a partial solution for Ontario along with implications for other provinces.

As of November 2018, there were approximately 4,500 ALC patients in Ontario occupying approximately 16% of relatively expensive hospital beds (CCO 2020). ALC stays are

associated with adverse health outcomes for patients due to accelerated functional decline, social isolation and loss of independence, as seen across Ontario and throughout the country (Petch 2012). During the fiscal year (FY) 2018, the province expended \$650 million on ALC patients at an average of approximately \$560 daily – nearly fourfold and fivefold the daily cost of long-term care and home care, respectively (MOH 2020a, 2020b). A 34.4% increase in direct hospital expenditures for ALC from FY 2013 to FY 2018 was driven by price inflation, population growth, aging and general increases in volume and changes in service mix (CIHI 2019; MOH 2020a). Furthermore, the percentage of in-patient bed-days in Ontario hospitals attributable to ALC grew from 14.0% in FY 2015 to approximately 17.0% by FY 2019 (CCO 2021). Continuing this trend, the ALC patient population is expected to grow from 3.1% to 3.7% annually by 2036, with an upturn expected in 2021 as baby boomers exceed the age of 75 years (Hermus et al. 2015). While ALC remains a growing problem, it is currently acute, as illustrated in Figure 1.

FIGURE 1. The magnitude of the ALC issue

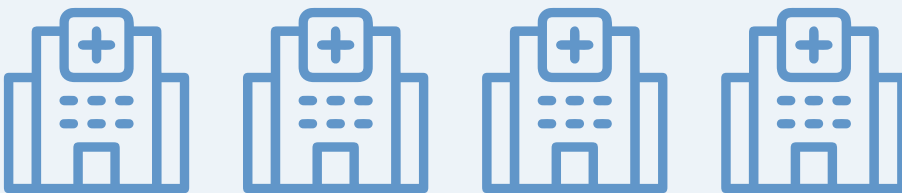
More than 90% of hospital patients can access home care promptly, but

1 in 12

**have their hospital stay extended until
homecare services or supports are ready**

= 4 large hospitals

(400 beds) every day



Source: CIHI 2021.
Reproduced with permission from CIHI.

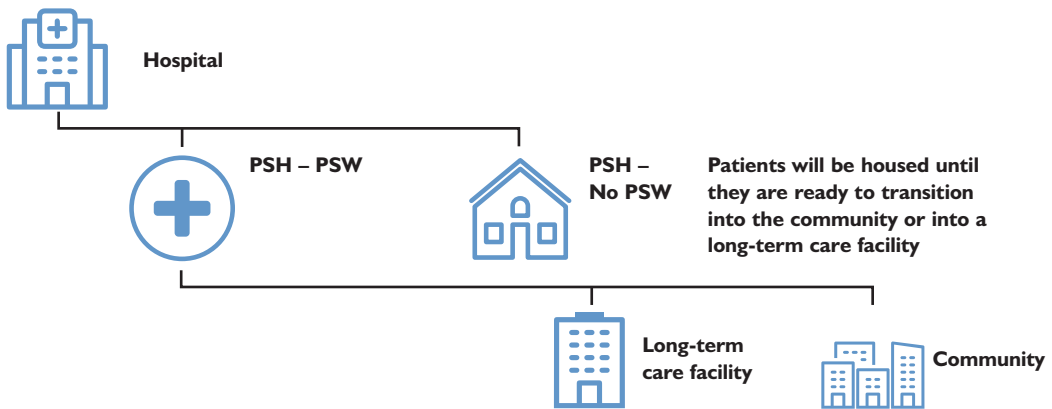
Given the status quo regarding alternatives to ALC care, and an ongoing shortage of labour in the community care sector limiting its potential expansion, Ontario will require new hospital construction to care for ALC patients in the near future, beyond that required for acute care services. Recent pan-Canadian research suggests that in-patient capacity can be increased by up to 11% if the ALC patient load is eliminated; therefore, given approximately 1.2 million in-patient stays in Ontario annually, it is estimated that Ontario's capacity might be increased by 132,000 in-patient stays if the ALC problem is totally alleviated (Basu et al. 2016; CIHI 2020).

Community-based care provides a less expensive alternative to ALC. However, growth in the senior population combined with both the shortage of community care nurses and poor retention of personal support workers (PSWs)¹ make it challenging to meet the growing demand for such services (Ontario Health Coalition 2019). Thus, reducing reliance on ALC will require other alternatives to sufficiently relieve hospital overcrowding. One option involves allowing homeowners who wish to leverage their homes as a source of income to get certified either as a PSW or with a lower level of certification with outside PSW support.² By doing so, they would engage in a public–private partnership with the provincial government to provide temporary personal support to selected discharged patients who would be waiting in hospitals as ALC patients. The basic idea is that patients would be discharged to the home of trained personnel rather than trained personnel travelling to clients’ homes. Similar in structure to Ontario’s Foster Care program for children or the LifeShare/Host Family program for adults with cognitive challenges, the suggested program could substitute for ALC, often allowing patients to recuperate nearer to their own community (Ontario MCCSS 2018a, 2018b). The program could further provide efficiencies by eliminating travel time for PSWs and/or community care nurses, and the province could save large sums in future hospital construction. This paper will explore the viability of a personal support home (PSH) initiative in Ontario.

Program Details

This program would provide care for the ALC population that is classified as not requiring any specialized needs or supports (non-SNS),³ which, as of the end of November 2019, comprised almost 35% of 1,655 ALC patients (CCO 2020). This equates to a total of 322,793 ALC days (CCO 2020). The two levels of care under this scheme can be best summarized as seen in Figure 2.

FIGURE 2. Two levels of care within the proposed PSH program



Some patients will be able to go to homes that provide more of a hotelling function plus food services, while others requiring greater support will be assigned homes with embedded PSWs. In general, the expected stay will be between three weeks and two months – based on current wait times in ALC beds – until a homecare or long-term care slot becomes available (CCO 2020).

Supply and Potential Demand for PSHs

A heatmap by census division ($n = 49$) of Ontario's spare bedroom supply in single-storey detached homes is shown (Figure 3) based on data provided by the Municipal Property Assessment Corporation (MPAC n.d.). Spare bedrooms are those that exceed the difference between the number of bedrooms and the number of permanent residents; thus, a residence with four bedrooms and three residents would have one extra bedroom, with one bedroom conservatively considered a home office and another bedroom considered as a shared bedroom.

Although the supply of spare bedrooms is known to be the greatest in rural and remote areas, spare bedrooms are also in sufficient supply in many urban and suburban areas with, perhaps, 20 residents in the census division per spare bedroom at the most. The four Ontario regions – defined by the now defunct Local Health Integration Networks (LHINs) – with the highest percentage of hospital days defined as ALC in FY 2019–20 are all considered rural or remote regions, and these regions have maintained this relative ranking over the past decade (Intellihealth 2015).⁴ That is, the highest ALC rates occur in those regions with the lowest rates of population per spare bedroom or, inversely, the highest number of spare bedrooms per person. According to the MPAC data, there were 997,123 spare bedrooms in one-storey detached homes in Ontario as of 2019. If just 0.1% (1 out of 1,000) of spare bedrooms in single-storey detached homes in Ontario became PSH beds (approximately 1,000 beds in 890 homes), 365,000 ALC bed-days⁵ could be made available. In terms of demand, if it is assumed that half of all non-SNS (i.e., eligible) ALC days (13.9% of total ALC days) were transferred to the PSH and that ALC bed-days (1.16 million) are uniformly distributed across all ALC categories, then approximately 161,396 (13.9%) bed-days (13.9% × 1.16 million) could be transferred (CCO 2020; MOH Health Data Branch 2020). This would result in an average PSH-bed occupancy rate of approximately 44.2% (which is equal to 161,396 bed-days expected in PSH/365,000 total bed-days potentially available under PSH).

Remuneration and Estimated PSH Program Savings

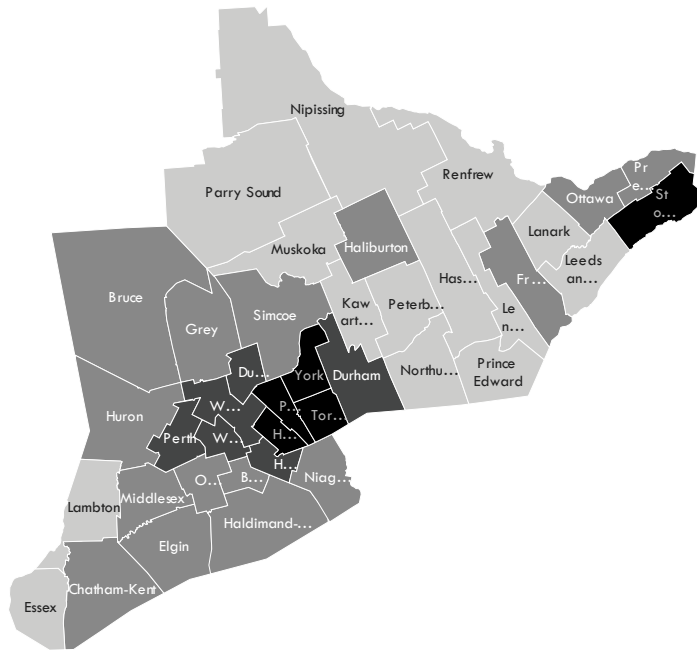
Remuneration could be set so that per diems would lie between the daily cost of home care (low) and long-term care (high) so as to incentivize discharge from the program toward the former.⁶ The relative costs, including ALC, are summarized in Figure 4.

The proposed remuneration would be between \$120 and \$150 per day, such that somebody who has two spare bedrooms and fills them 250 days per year with PSH clients – approximating a full-time endeavour – could earn an annual income ranging from \$60,000 to \$75,000.⁷

FIGURE 3. Heatmaps for supply of spare bedrooms in Ontario

Southern Ontario

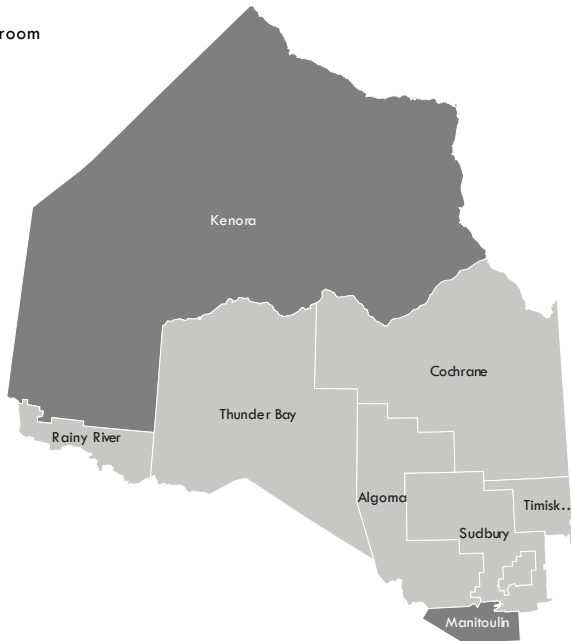
Population per spare bedroom



Spare bedroom supply is the greatest in rural/remote areas

Northern Ontario

Population per spare bedroom

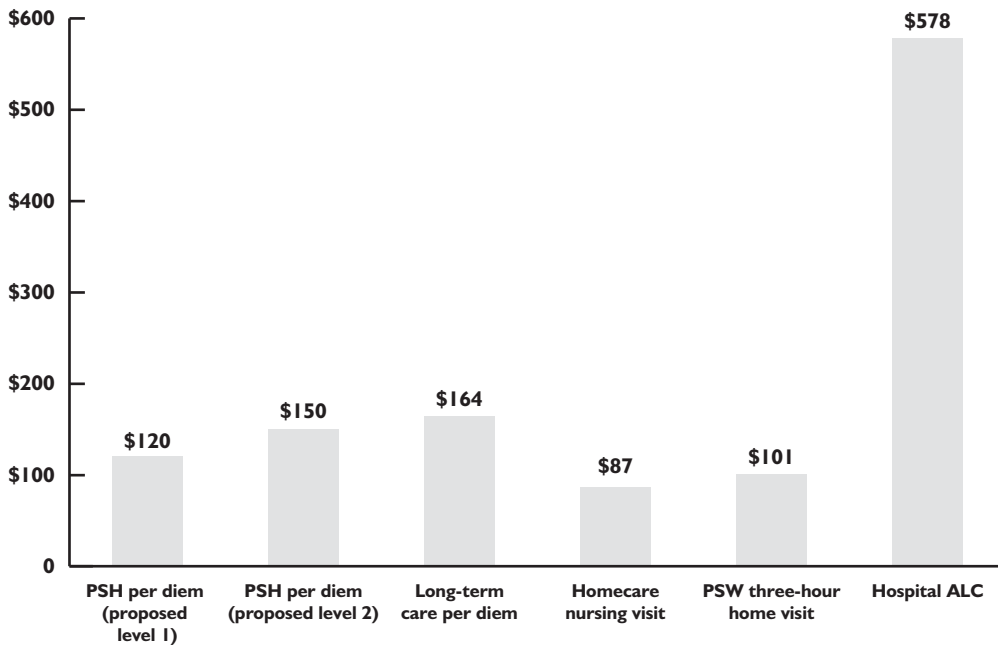


Source: MPAC n.d.

An Innovative Approach to Reduce the Alternative Level of Care Population in Ontario Hospitals

Regarding potential savings, a PSH initiative could save the province between \$1.13 and \$1.95 billion⁸ from future hospital construction (Infrastructure Ontario 2007; see Table 1 and Appendix 1, available online at longwoods.com/content/26575). Beyond these benefits, this initiative could also free up hospital capacity to serve other patients. The cost savings calculations are summarized in Table 1.

FIGURE 4. Daily cost comparison: PSHs, home care and long-term care



Sources: Ontario Healthcare Financial and Statistical Database (OHFS); Ontario Ministry of Health and Long-Term Care 2015.

TABLE 1. Potential cost savings to the province

Measure	Calculation	Figure
Bed-days from ALC to PSH		161,396
Foregone beds	161,396/365	442
Construction cost per bed		\$2.56 million/bed to \$4.42 million/bed
Savings from foregone hospital construction	\$2.56 million/bed to \$4.42 million/bed × 442 beds	\$1.13 billion to \$1.95 billion

The PSH program is expected to relieve current hospital system pressures.

Discussion

PSHs would partially address two health policy problems: reducing the large number of ALC patients straining hospital beds and attracting new PSWs, who are increasingly in short-supply. The first has been the focus of this paper, but the second is no less important. By allowing people to leverage their homes, this initiative provides a new service model for

PSWs that has the clients come to the PSW rather than the other way around. This not only eliminates PSWs' commute time but also potentially allows PSWs to care for two clients simultaneously.

There are a number of challenges associated with decentralized programs such as the PSH. One of these regards accountability and client safety, which requires amending the *Regulated Health Professions Act, 1991*; the *Medicine Act, 1991*; and associated regulations dealing with scope of practice for both PSWs and community care nurses (Hamilton 2018). The residential aspect of the PSH may require new regulations to ensure adequate homeowner and potential client selection/matching criteria, oversight and accountability of PSWs and others who register to provide such services. Currently, the regulations are quite limited with regard to both delegated and exempted acts that unregulated PSWs may perform, and these may need better delineation for those who provide residential services; furthermore, community care nurses are not generally placed in an oversight capacity, requiring changes to scope of practice through legislative and/or regulatory amendments (Hamilton 2018).

A potential platform for establishing accountability and oversight might come from a policy directive issued in 2016 aimed at Ontario's LifeShare/Host Family Program under the auspices of Ontario's Ministry of Children, Community and Social Services (MCCSS). Due to several reports of maltreatment and a sentinel event involving the death of a resident, this directive provided new safeguards for clients, strengthening the process for screening, selecting and evaluating host families alongside ensuring consistent service delivery (Ontario MCCSS 2016; Riordon 2017).

A second challenge involves the potential to crowd out other provincial programs that depend on community members to participate by offering their residences to house others. The two current programs in competition with the PSH for homeowners are the already mentioned Foster Care program for children and the LifeShare/Host Family Program. With regard to the first, most foster care families tend to be younger (aged 30–50 years) with children of their own still at home, while the PSH would target older Ontarians with grown children leaving behind spare bedrooms; thus, the pool of families or individuals from which these programs would draw are unlikely to intersect (Rodger et al. 2006). With regard to the LifeShare/Host Family program, the families participate under the guise of a long-term obligation, while PSH registrants would understand that they would be entering into shorter term relationships. This allows PSH families greater flexibility in hosting clients at any particular time. In essence, preferences for length of commitment would allow families to self-select themselves into two mutually separate groups, minimizing the possibility that PSH would negatively impact the pool of families available for the other programs. Finally, PSHs may potentially compete somewhat with Airbnbs as people try to leverage their residences to generate income, and this may be a welcome development for many who complain about the negative effects of Airbnbs on their neighbourhoods (Maclaren Municipal Consulting, Inc. 2019).

A third challenge arises from difficulties in establishing certification and training. For instance, establishing what constitutes a “hotelling” function that is separate from a PSW function may not always be clear as these may not be mutually exclusive roles. Furthermore, it is not clear what proportion of PSHs will opt for either certification, perhaps leading to a maldistribution of the two levels of homes offered. A potential solution is to vary the level of remuneration offered to the two levels of care to incent the proper distribution of homes between them.

Initiatives similar to the PSH have been initiated with varying degrees of success in the UK and the US and in British Columbia, Canada. In the UK, there was a short-lived initiative of an Airbnb-style scheme in which homeowners were paid the equivalent of C\$1,700 per month to house patients clinically appropriate for hospital discharge (Clarke 2017). While the intention was to limit hospitalizations to clinically appropriate periods, the initiative was poorly explained to the public, with the optics suggesting that the program was a privatization scheme supplanting the British National Health Service; thus, the ensuing political backlash forced the government to abandon this initiative (Clarke 2017). First established in Florida in 2015, the private online platform room2care.com established a marketplace for individuals to find a place to recuperate after a hospital stay (Room2Care 2015). The program makes recommendations to seniors regarding housing options, but seniors negotiate directly with hosts regarding the price and services delivered. The goal of the program is to provide care for 50% of the prevailing rates for other housing options (e.g., assisted living) that have a median price of the equivalent of approximately C\$4,000 per month (Room2Care 2015). In British Columbia, the Family Care Homes program provides services in unlicensed single-family residences that accommodate up to two clients – down from four clients during the early 2000s – with supportive accommodation post-hospitalization (J. Zhang, personal communication, July 17, 2020). Services include meals, laundry, housekeeping services and supervision, along with any assistance with daily living activities such as bathing, grooming and dressing, with clients expected to pay out of pocket the same rate that is assessed for long-term care (British Columbia n.d.). Focusing on serving sparsely populated areas rather than on reducing ALC days *per se*, the program was designed to provide a long-term residence in lieu of placement in a standard long-term care facility; however, the program could potentially assist with lessening ALC days (British Columbia n.d.). To date, there are no evaluations assessing the impact of this program on ALC rates, the potential for crowding out Airbnb and the rate of uptake and relative cost to other options (J. Zhang, personal communication, July 17, 2020).

One other prominent program is the Medical Foster Homes program run by the US Department of Veterans Affairs (2020). These are private homes in which a licensed homeowner/caregiver provides services to a few other residents, some of whom are service veterans. The US Department of Veterans Affairs is responsible for oversight by inspecting and approving these homes designed to serve as an alternative to a long-term care facility (US Department of Veterans Affairs 2020). The licensed caregivers assist with carrying out

activities of daily living, such as bathing and dressing, and the US Department of Veterans Affairs (2020) also ensures that residents receive home-based primary care. Of noted importance is that the program provides housing and care for more than 1,000 veterans in 42 states and Puerto Rico at an annual cost of \$20.7 million (Kime 2018). Veterans pay between US\$1,500 and US\$3,000 a month to live in such a home, and by doing so, they save the Veterans Affairs an estimated US\$10,000 a month in long-term care expenses over a traditional long-term care setting (Kime 2018). Yet, the strict qualifications that such homes must meet have impeded growth, and it still remains a niche program (Kime 2018).

A careful roll-out of the PSH program would help to avoid the pitfalls experienced by similar initiatives in other jurisdictions. In particular, a slow initiation with perhaps a few pilot programs in rural and remote areas where the needs are high, quaternary and tertiary care is received at the greatest distances from home and the spare bed supply is the greatest might be a prudent approach.

Although insufficient to solve the ALC problem in itself, the PSH initiative could be part of a multi-pronged approach to alleviating this growing pressure. More funding for home care by increasing the remuneration for community care nurses alongside funding for more training slots and retention programs for both nurses and PSWs is another prong. Still another strategy is increased funding for assisted living facilities as well as various short-term transitional care facilities designed to provide domicile space alternative to ALC beds in hospitals. Bundling payments to hospitals for patient care that includes the post-hospitalization recuperation period may provide financial incentives for hospitals to find placements for recuperating patients in the community. Finally, increased tax deduction/credits for caregiving by family members may increase family involvement in caring for sick family members.

In other provinces, the policy options and challenges faced are similar to those in Ontario; however, there are some important exceptions (Basu et al. 2016). While over 5% of discharged patients need ALC in Ontario, at the most, approximately 2.5% of patients are ALC in other provinces. This suggests that Ontario has the most urgent problem (Basu et al. 2016). Nevertheless, there are provinces with average stays that are longer than that in Ontario, such as Nova Scotia, and the mortality rate under ALC designation is higher in other provinces as well (Basu et al. 2016). This suggests that although some provinces have not nearly the patient load dedicated to ALC, they are experiencing more acute problems in discharging the ALC patients they do have. In terms of policy instruments, some regions of Ontario, Alberta, New Brunswick and Nova Scotia have instituted regulations that make ALC a chargeable-to-patient hospital service on a sliding scale according to income; thereby, patients may not find it financially favourable to stay in ALC, making patient decision-making more incentive-neutral (Basu et al. 2016; Hamilton Health Sciences 2019). All of this suggests that no single solution such as adding long-term care beds or providing more homecare slots would be sufficient to match the exact fluctuating needs and preferences for ALC patient discharge at any particular point in time (Hermus et al. 2015). Even PSHs may only be partially helpful as the business model is often not viable where real estate prices are

excessive and remuneration may be insufficient to cover mortgage or rent expenses (J. Zhang, personal communication, July 17, 2020).

Conclusion

A PSH program would allow many Ontarians to recuperate post-hospitalization nearer to their community of residence with greater dignity than in a hospital at less than a third of the daily cost without risking further exposure to hospital-based infections. With the impending uptick in the frail elderly as the baby boomer generation ages beyond 75 years, time is of the essence. The most recent Ontario provincial budget calls for \$30.9 billion for new hospital infrastructure over the next decade, with an ever-growing demand for such infrastructure (Government of Ontario 2021). This money could be more optimally spent freeing up hospital capacity to serve greater numbers of acute care patients – for which there is a growing demand. The future is now, and innovative approaches to impending health policy dilemmas need to be considered alongside more conventional approaches to solve these problems.

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Notes

1. PSWs are unregulated professionals who care for people who are ill, elderly or need help with daily tasks.
2. The notion under this concept is that existing PSWs would not be eligible to participate in this program; only new applicants desiring to obtain this training would be eligible so as not to crowd out existing PSW capacity.
3. Non-SNS patients are those without dementia, complex medical needs or impaired mobility issues.
4. These LHIN regions include Central East LHIN, North Simcoe-Muskoka LHIN, Northeast LHIN and Northwest LHIN.
5. $1,000 \text{ beds} \times 365 \text{ days/year} = 365,000 \text{ bed-days}$.
6. A handful of non-SNS ALC patients have been destined for other destinations including mental health, rehabilitation centres, palliative care, etc., but these account for less than 3% of such discharges (15 out of 575 non-SNS ALC patients) (CCO 2020).
7. $\$120 \text{ per day} \times 250 \text{ days} \times 2 \text{ clients} = \$60,000$.
 $\$150 \text{ per day} \times 250 \text{ days} \times 2 \text{ clients} = \$75,000 \text{ annually}$.
8. It should be noted that some hospitals are constructed without any new in-patient beds (e.g., the new Women's College Hospital in Toronto, ON, is an ambulatory care hospital), and there are other purposes for hospital expansion beyond growth in bed capacity that include capital-intensive innovations involving new types of surgery, imaging, etc.). Thus, the cost per bed does factor in these complementary indirect costs as well as the direct costs of providing added bed capacity.

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