Advancing Home and Community Care in Ontario: Submission to the Home and Community Care Expert Group, 2014

HOME CARE ONTARIO

October 2014

Mission

To promote growth and development of the home and community health care sector through advocacy, knowledge transfer and member service.

Vision

The Voice of Home Care in Ontario™

Values

Home Care Ontario is:

- Respectful
- Inclusive
- Responsive
- Receptive
- Balanced
- Trustworthy

Advocacy within the health care system

Home Care Ontario™ is a leader in promoting the provision of adequate financial and other resources for the home and community care sector in Ontario. The Association participates regularly, both federally and provincially, in task forces, consultations and committees in order to develop consistent approaches to policy and funding issues affecting home and community care service provision for Ontarians.

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Home and Community Care

Executive Summary

This paper has been developed in response to the call by the Home and Community Care Expert Group[1] for information about what is working well and where improvements can be made in the sector. The mandate of the Group is to provide the Minister of Health & Long-Term Care with "specific, practical recommendations to bring the home and community care sector to a more integrated, accessible, responsive and equitable system for individuals in need and their caregivers (both paid and unpaid)".[2] This advice is to be provided by January 31, 2015 and the Group has requested input via survey by October 31, 2015. Home Care Ontario has submitted a response to the survey online and provides this paper as a companion piece to further inform all who are interested in home care in Ontario.

Home care is a publicly funded, not a publicly insured, service. In Ontario, publicly funded home care falls under the jurisdiction of the Ministry of Health and Long-Term Care (MOHLTC), which has steadily increased its investment in order to meet the increasing demand. Notwithstanding, the mandate of the publicly funded system is to support families to provide care at home. Families provide the majority of care at home, and to manage, many choose to use private funds to retain home care service provider organizations.

This paper addresses the questions posed in Home and Community Care Expert Group Survey 2014.

In Ontario the publicly funded home care program is locally administered by 14 Community Care Access Centres (CCACs) across the province.[3] CCACs are accountable to the Local Health Integrated Networks (LHINs). CCACs serve to provide a simplified service access point and are responsible for determining eligibility for and buying on behalf of consumers the highest quality, best priced visiting professional and homemaker[4] services provided at home and in publicly-funded schools. CCACs also provide information and referral to the public on community-related services and authorize admissions to long-term care homes.[5]

There is much to be proud of and many accomplishments over the 45-year history of publicly funded home care in Ontario. The sector has expanded and evolved to provide almost 38 million visits/hours[6] of high quality care to Ontarians per year. However, all would agree that more investment in home and community is required to meet the increasing reliance on home care as a vital component of an effective health care system.

This paper follows the approach of the survey issued by the Home and Community Care Expert Group and as such provides only the most notable successes and improvement opportunities specific to publicly funded service. More information about the full scope of home care services – those purchased privately and publicly can be found at www.homecareontario.ca.

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[1] List of experts with brief biography at http://www.health.gov.on.ca/en/news/bulletin/2014/bg_20140424_1.aspx
[2] Letter requesting input received on October 3, 2014. Retrieved from http://www.homecareontario.ca/docs/default-source/news/h-c-care-review---stakeholder-survey-cover-letter-final.pdf?sfvrsn=0
[3] A listing of CCACs can be found at http://www.ccac-ont.ca/Locator.aspx?MenuID=70&PostalCode=Enter%20Postal%20Code&LanguageID=1&EnterpriseID=15
[4] Homemaker serves as the generic term to describe the person who provides personal care, homemaking services and/or respite to enable the individual to remain at home in a safe and acceptable environment
[5] Canadian Home Care Association. (2008) Portraits of Home Care. p80
[6] MOH Health Data Branch Web Portal. Analysis of 2013/2014 YE 2013/2014 YE reports.

The Survey Questions

1. What are the three greatest sources of frustration for individuals in need and their families/unpaid caregivers who are receiving home and community care? **What are the home and community care sector's three greatest successes? What specific change(s) could be made to address these frustrations and/or build on these successes?**

2. **What are three specific changes you believe would increase the coordination and integration of services** (e.g., hospital transitions, primary care, home and community care, social services) for individuals in need and their families/unpaid caregivers so that they can be active participants in planning and managing their own care and be well supported in that role?

3. **What are three specific ways that providers of home and community care could better meet the needs of individuals in need and their families/unpaid caregivers?**

4. Health care consumes a significant portion of the provincial budget, and these costs are growing. **What innovations and new approaches to care delivery could be made to maximize the value of our investment in home and community care?** Where are the greatest opportunities for impact?

5. Please comment on any additional issue that is not addressed in the above questions but that you feel will help the Expert Group develop its recommendations.

Overview

Most, if not all, people wish to remain independent at home in their community during their older years. Successful aging requires a holistic approach – avoiding disease and disability; maintaining cognitive ability; and engaging with life.[7] One of the most significant and least desirable outcomes for a community dwelling senior is to be prematurely institutionalized[8] because of the lack of home and community care based health and social support options.

Home Care and Community Services

Home care is defined as an integrated "array of services, provided in the home and community setting, that encompass health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration and support for the family caregiver".[9] [10]

The provision of publicly funded and privately retained home care allows Ontarians of all ages the opportunity to recover or manage their health care issues and age at home surrounded by family, friends and their community to which they can continue to make a meaningful contribution.

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[7] Rowe, J. W., & Kahn, R. L. *Successful aging.* Gerontologist, *37*, 433–440, 1997

[8] For the purposes of this paper, institutionalization is understood to be a setting where decision-making related to ADLs (such as meals, baths and bedtimes) is outside of the control of the individual.

[9] Canadian Home Care Association

[10] For more about home care in Ontario, see Appendix 1.

Services within home care include nursing, personal support/homemaker, therapy (including physiotherapy, occupational therapy, speech language pathology, social work, nutrition/dietetics), medical supplies and equipment in the home. Home care in Ontario is delivered by service provider agencies that meet high standards of excellence identified through rigorous performance evaluation administered by CCACs.

Home care programs work with community support services such as day programs, respite care facilities, volunteer services, Meals on Wheels and transportation services. Clients' needs are met in a comprehensive way when a close linkage exists between the delivery system, which provides both physical and social support.

There is a synergistic relationship between home care and community services that enables individuals to remain at home.

There is a synergistic relationship between home care and community services which is further supported and described as 'the provision of health care, community and social support programs that enable individuals to receive care at home and/or live as independently a as possible in the community'.[11]

An efficient and effective publicly funded home care system appropriately includes and integrates all members of the team to achieve value and to assist Ontarians to remain independent at home. Safe, reliable privately funded home care services can offer additional capacity to the system and provide even more choice to Ontarians. The full array of home care services, including access to case management, family physicians, nursing, therapies, community pharmacists and personal support and community support is essential to support good health outcomes.

Successes in Home and Community Care

Home care was formally established in Ontario in 1970 and has grown and evolved as a sector over the past 40 years. There have been many successes and today the home care system is responsible for providing care at home to close to 700,000 Ontarians per year.[12] As the largest home care program in Canada, Ontario leads the way in building a system driven by quality and evaluated on several dimensions.

Role Clarity

Separating the direct service provision and the program authorization responsibilities of the CCACs mitigates the risk of a conflict of interest regarding eligibility and services providing a system of 'checks and balances' for the recipients of care. "CCAC case managers are most importantly neutral brokers who act on behalf of clients."[13]

"Case Managers derive no direct benefit from the services they provide"

Community Care Access Centres Bringing Value Home

The CCACs serve as the point of access for care in the community. The role of the CCAC case manager as the administrator and patient navigator complements the service

[11]Report to the Annual Premiers' Conference, "Strengthening home and community care across Canada: A collaborative strategy, August 2003

[12] MOH Health Data Branch Web Portal. Analysis of 2013/2014 YE 2013/2014 YE reports.

[13] Community Care Access Centres Bringing Value Home. Retrieved from http://oaccac.com/Policy/Documents/papers%20and%20reports/Bringing%20Value%20Home.pdf

provider position as the clinical manager responsible to facilitate safe and appropriate care.

The CCAC case management role has two key functions: 1) "administrator" of publicly funded home and community care; and, 2) the "patient navigator" to services within the broader health system. The administrator function includes responsibility for determining access to service, service analytics, and contract performance management. The patient navigator activities are to provide care and support of those with complex need and limited capacity to manage without guidance and assistance.

The CCAC case management role is that of administrator and patient navigator.

The service provider organization is accountable for direct clinical care at the frontline ("bedside") and is accountable for clinical expertise and evidence-based practice, risk, performance and quality management and patient outcome.

All health care staff is responsible to support good communication and smooth transition of client/family information when making a referral. Enhanced communication and better information about the capacity of the system is essential to avoiding the situation whereby untenable promises are made by hospital staff or physicians, for example, regarding the amount and level of home care service. When promises are not aligned with actual resources and abilities, confidence in the system is compromised.

Intensive Support

The Home First for the "at risk" ALC patient, which is a strategy of providing intensive support to enable successful transitions from hospital back to the community so as to avoid precipitous decisions at a time of crisis about capacity to cope at home. The program works well for individuals whose care needs are not exceedingly complex and who can return close to pre-hospitalization function once they are over their health incident and re-stabilized at home. The short-term intensive support, when applied to the less complex client, has been demonstrated to avoid the need for institutional placement.[14] [15]

Short-term intensive home care support supports successful transitions from hospital to the community.

Recent Canadian and international research suggests that community-based services that are integrated and co-ordinated across the health care system can be a cost-effective way to maintain seniors' independence and prevent premature admissions to hospitals and long-term care facilities.[16] The availability of home care services can facilitate early discharge from an institution effectively addressing the number of patients waiting in hospitals that do not require intensive / acute care – a challenge in Ontario's health system.

Ontarians want to receive care in their homes, and if given a choice would prefer early discharge from hospital followed by provision of home care. Enhanced and focused

[14] VanderBent, S.; Kuchta, B. (2010) Valuing Home and Community Care. http://www.homecareontario.ca/docs/default-source/publications-mo/valuing-home-and-community-care.pdf?sfvrsn=4
[15] Canadian Home Care Association. (2010) Home First: Maximizing use of investments while creating better outcomes for seniors and reducing ALC. High Impact Practice. Retrieved from http://www.cdnhomecare.ca/media.php?mid=2422
[16] Béland F. et al (2006) *A system of integrated care for older persons with disabilities in Canada: Results from a randomized controlled trial,* J Gerontol A Biol Sci Med Sci. 2006 Apr; 61(4):367-73.

services delivered in the home can make a major difference in the quality of life for both the senior and their families.[17] Acknowledging home as the care destination should trigger care decisions that consider the context of maximizing independence at home.

Quality and Value

CCACs and service provider organizations have achieved a new contractual arrangement that is based on quality. The old competitive based request-for-proposal (RFP) process has been replaced by a quality-based contract centred on established performance metrics and patient outcomes.

Tiered indicators are used to measure performance in home care in Ontario. There are contractual measures that all service provider organizations in Ontario are obligated to report. These are:

- Client Satisfaction
- Missed Care
- Referral Acceptance Rate
- Discharge Report Rate

The CCAC uses these measures to assess and benchmark service provider performance to established standards. In addition, CCACs have performance measures unique to their jurisdiction on which they require data.

Work has been initiated to examine performance based on outcome indicators for specific populations. This work lays the foundation for future bundled payment models.

Additionally "HQO reports information on the quality of home care services for CCAC clients with chronic conditions and/or complex medical needs requiring care over an extended period to:

- Help monitor home care service delivery
- Identify areas that may need improvement, and
- Gain a deeper understanding of the characteristics that contribute to variations in quality."[18]

Service provider organization level reporting is under development.

Addressing Frustrations and Building on Successes

The home care system is achieving excellence and contributing to the health and independence of Ontarians through continuous improvement, innovation and best practice. Notwithstanding, there are areas where most would agree that improvements can, and should be made.

Since 2010/11 most clients served by CCAC are defined as having "high care needs".[19] With increasing pressure to protect hospitals from inappropriate utilization and congestion, publicly funded home care services have been increasingly used to address the needs of post-acute care patients. CCAC patient acuity has increased (in 2012-13 the percentage of CCAC patients with "high care needs" was 58.1% - an increase from 37.4%

[17] Challis, D. and Hughes, J. (2002) p 126-130
[18] Health Quality Ontario website, http://www.hqontario.ca/public-reporting/home-care
[19] How We Care 2012 -2013 CCAC Quality Report - http://oaccac.com/Quality/Documents1/2012-2013-CCAC-Quality-Report-EN.pdf

in 2009-10)[20] [21] and as a result there have been diminished resources for those frail elderly with longer term, lower acuity needs, including seniors who are at risk of loss of independence or "at the margins" of requiring institutionalization.

Providing Client-Enabling Care

Adopting a proactive / preventative care approach in the home has been proven to be effective in supporting seniors to avoid the need for additional health care.[22] [23] [24] [25] While seniors today are typically healthier and more independent longer in life, the demographic shift is driving the need in Ontario to broaden the approach to health care and leverage resources to support seniors to remain independent at home for as long as possible.

A proactive approach is effective in avoiding the need for additional health care.

As the number of elderly people in the population grows, so will the prevalence of age-related chronic conditions that may jeopardize an individual's ability to live independently in the community."[26] Models of proactive, targeted nurse led care that focus on preventive patient self-management for people with chronic disease are either more effective and equally or less costly, or are equally effective and less costly than the usual model of care.[27]

Current funding limitations and rigid service criteria for CCAC services do not align or respond to real world challenges, such as the "at risk" senior who needs a small increase in service beyond established limits, or budget capacity to remain at home. These are the people, who may or may not be compromised by chronic disease but who are at the 'fringe' of stability. They need a little more support than offered within the community system but not the full scope of services offered in the facility. Or, they may be at end-of-life and need a little more support than allowed in a given week as in the case where a person with clearly less than 72 hours to live is only authorized 56 hours of service per week.[28] It is at times like this where enhanced and focused services delivered in the home make a major difference in patient/family quality of life and in the use of health system resources.

Community-dwelling seniors 'at risk' for loss of independence benefit from preventative and flexible home care.

[20] Ibid
[21] See Appendix 2 for CCAC stats
[22] Markle-Reid, M., Browne, G., Weir, R., Gafni, A., Roberts, J., Henderson, S. (2008). Seniors at Risk: The Association between the Six-Month Use of Publicly Funded Home Support Services & Quality of Life & Use of Health Services for Older People. Canadian Journal of Aging 27 (2): 207-224
[23] Markle-Reid, M., Weir, R., Browne, G., Henderson, S., Roberts, J., Gafni, A. (2004) - Frail Elderly Homecare Clients: The Costs and Effects of Adding Nursing Health Promotion and Preventive Care to Personal Support Services. System-Linked Research Unit Working Paper S04-01
[24] Hollander, M., Chappell, N. (2002) *Final Report of the National Evaluation of the Cost-Effectiveness of Home Care*, Health Transition Fund (2a)
[25] Hollander, M.J., Chappell, N.L., Prince, M., Shapiro, E. (2007) *Providing Care and Support for an Aging Population: Briefing Notes on Key Policy Issues*. Healthcare Quarterly Vol. 10, No. 3: 34-45.
[26] Statistics Canada. 2006. *Seniors and Home Care*. Stats Can Catalogue no. 82-003-XIE. Ottawa. www.statscan.ca
[27] Browne, G.; Birch S.; Thabane, L. (2012) Better Care: An Analysis of Nursing and Healthcare System Outcomes. CHSRF.
[28] Oral report. (October 2014) Situation reported by a palliative care nurse in a focus group session.

Proactive Interventions

A randomized controlled trial has presented clear evidence that providing seniors with proactive nursing health promotion compared to providing professional services on demand, results in enhanced quality of life related to early identification and management of risks for adverse events (e.g. falls, polypharmacy, depression, caregiver stress) at no additional expense.[29] Another study shows that if a nurse visits an individual within seven days of discharge from hospital the likelihood of readmission is reduced by 20-25%.[30] However the amount of nursing service provided annually through the CCAC has not changed despite a 14% increase in the numbers of clients served.[31]

If a nurse visits an individual within seven days of discharge from hospital the likelihood of readmission is reduced by 20-25%.

Ontario's Valuing Home & Community Care initiative provides solid evidence as to the cost and care effectiveness of proactive home care for seniors with moderate impairments.[32] This study showed significant savings to the health system and improvements to quality of life for frail individuals over the age of 75 years through the provision of home care services.[33]

As foundational to the health care system home care and primary care collaboration on proactive interventions have been proven to avoid the need for hospitalization and prevent health related crises.[34] [35]

A Fundamental Right

Home care should be treated as *a fundamental right of all Ontarians* and referrals (regardless of source) should result in service until a formal CCAC assessment and/or patient navigation by CCAC case management can be supported. Currently individuals must wait until an assessment, which is often lengthy and redundant to assessments done by other providers within the system, can be completed. Paperwork before care is counterintuitive to the belief in Canada that the frail and vulnerable should have unfettered access to care.

Care trumps paperwork and home care is fundamental.

Paperwork processes have been waived and service provider organizations have been authorized to initiate service during crises such as labour disruption at the CCAC and the SARS outbreak of 2003. The approach was proven to be effective and to have prevented individuals from needlessly seeking care in hospital.

A right to home care service supports families especially when they have exceeded physical and emotional ability to cope and would otherwise seek an institutional resource. The current home care system depends heavily on family and friends to provide the

[29] M. Markle-Reid, et al. Frail Elderly Home Care Clients: The Costs and Effects of Adding Nursing Health Promotion to Personal Support Services. Ottawa, Ontario: Canadian Health Services Research Foundation, 2003.
[30] ICES. (2011) Health System Use by Frail Ontario Seniors: An in-depth examination of four vulnerable cohorts. Chapter 5 Medically Complex Home Care Clients.
[31] MOH Health Data Branch Web Portal. Analysis of 2013/2014 YE 2013/2014YE reports.
[32] VanderBent, S.; Kuchta, B. (2010) Valuing Home and Community Care. http://www.homecareontario.ca/docs/default-source/publications-mo/valuing-home-and-community-care.pdf?sfvrsn=4
[33] Ibid
[34] Canadian Home Care Association. (2012) Home is Best: Developing an Integrated Primary and Home & Community Care System. High Impact Practice. Retrieved from: http://www.cdnhomecare.ca/media.php?mid=2906
[35] Canadian Home Care Association. (2006) Partnership in Practice. Ottawa.

majority of continuous care and support in the community and this is unsustainable for many families.[36] While caregiving is a positive experience for many, family members can struggle to balance the competing demands of work, family and care for elders.

Supporting Families

Families are increasingly called upon to do more in the home as in the case where an 89-year-old woman was directed to be responsible for changing the colostomy bag for her 87-year-old brother.[37] The publicly funded home care system relies on family members extensively but flexibility and judgment as to the amount of pressure placed on families must prevail. On demand respite for families so they can continue providing the necessary care at home has been demonstrated to be both cost and care effective.[38]

Research has shown that family counselling and mental/emotional health support for caregivers can reduce the rate of institutionalization for some groups of seniors with Alzheimer's disease.[39] Investment in planned respite that addresses the caregivers' needs and acknowledges their importance to keeping our elders at home is critical to ensuring the sustainability of the caregiver role.

What do you need to be at home?

Changing the Paradigm

With the increasing reliance on home-based care, the health system needs to re-orient to drive a home-based solution ("what do you need to be at home?") at every opportunity. Rationale for other options needs to be based on defensible evidence. This will necessitate a shift in resources, metrics and a paradigm shift from hospital value proposition to the cycle of care value proposition.[40] For example, elderly patients who present to the emergency room with a fracture should be screened for home care.

The home care system must shift from predefined service limits, visit times and defined tasks to one that is responsive to the person's rights and wishes in their own home. Access to supplies and high quality products, such as wound care treatments that are available in other health care settings should be funded by CCAC so as to avoid creating a perception of a lesser standard in the community.

Home and community care must shift from predefined service limits, visit times and defined tasks to one that is responsive to the person's rights, wishes and needs in their own home.

The ability to remain at home is in large part determined by an individual's ability to manage their living circumstances, whether it is a house in a rural or urban setting, an apartment or assisted living environment. Social isolation and escalating fears about safety risks can prompt the family and/or the health care team to recommend an institutional option. The work of maintaining a home, cleaning, snow shovelling, and home repairs can become too difficult for seniors and their families. Research has shown

[36] Naleppa, MJ. Families and the Institutionalized Elderly, *Journal of Gerontological Social Work,* Volume : 27 Issue : 1 / 2, 1994 (p.87)
[37] October 2014 Oral report by public stakeholder in private conversation.
[38] Meredith, G. (2003) respite for Family Caregivers Program: Final Evaluation Report. Hamilton. For the J.W. McConnell Family Foundation. Retrieved from: http://www.von.ca/carerenewal/eng/pdfs/FinalEvaluationReport.pdf
[39] Mittelman MS., Ferris SH., Steinberg, G., Shulman E., MacKell JA., Ambinder A., and Cohen J., "An Intervention that delays institutionalization of Alzheimer's disease patients: treatment of spouse-caregivers" *The Gerontologist*, Vol 33, Issue 6 730-740 1993
[40] Porter, M.E. and E.O. Teisberg. 2006. Redefining Health Care: Creating Value-Based Competition on Results. Boston, MA: Harvard Business School Press.

that the balance of care can be tipped to remaining at home when supports that address isolation and simple assistance with home maintenance are provided.[41]

"Right Provider, Right Place, Right Time"

Greater discernment about client needs involves trust in the members of the team and continuous and regular examination of roles, responsibilities, and tasks. The CCAC case management role should be streamlined to support clients with the most complex needs (top of pyramid). This population consumes the majority of health care resources and are the most vulnerable. Intensive support is required to help those with complex needs and multiple comorbid conditions to navigate the system and to serve as an advocate.

The creep by CCACs into clinical service provision obscures roles, creates duplication, confusion and mitigates the future role as case manager as envisioned by the OACCAC.[42] [43] Service provider organizations have well-honed care delivery procedures and processes. They have invested in training, education and clinical practices specific to the home setting. Service provider organizations have established risk management mechanisms and liability protection. As experts in care delivery, service provider organizations should not be subject to micro level oversight; for example, the type of staff to send, the time of the visit, the type of supply to use, etc. Service provider organizations recognize and embrace the opportunity to be measured on the outcomes they achieve for those they responsibly serve.

Provincial benchmarking on the resources used and outcomes achieved at a patient and population level should be expedited in order to drive best performance. Responsibility for care delivery must be devolved from CCAC to service provider (doctors, service providers, retirement home, long-term care home or hospital staff). The home care service provider would be responsible for clinical care outcomes through the direct responsibility for the care delivery team and products used.

Seniors are particularly vulnerable to the lack of coordination and communication between different sectors in the health care system.

Improving Coordination and Integration of Services

Currently there is no clear understanding by health system partners of the rationale for the amount and type of CCAC services. Families do not understand that home care is publicly funded; that it can be privately purchased; that tools, such as the RAI assessment, guide decision-making regarding the approach to care and that they are entitled to know the outcome of the assessment.

It is imperative that providers coordinate care and that clients/patients are supported as key members of the integrated team. Many seniors are particularly vulnerable to the lack of coordination and communication between different sectors in the health care system.[44] Recent hospitalization and poor transition planning following discharge from acute care is

[41] Challis, D. and Hughes, J. (2002) Frail old people at the margins of care: some recent research findings British Journal of Psychiatry 180 126-130

[42] OACCAC. (2014) Making Way for Change: Transforming Home and Community Care for Ontarians. Retrieved from: http://oaccac.com/Policy/White%20Paper/OACCAC-Whitepaper-FINAL.pdf

[43] Ibid

[44] McWilliams, C.(1993) Achieving The Transition From Hospital To Home: How Older Patients And Their Caregivers Experience The Discharge Process. Centre for Studies in Family Medicine, The University of Western Ontario, London

a known precursor of loss of independent living.[45] This occurs because appropriate supports (such as assessments and care plans) to enable a durable discharge are not planned and communicated to the next caregiver. An integrated and effective health system addresses the transition points of care and works to ensure safe and consistent bridging of services and/or sectors.[46]

Provider Collaboration

Effective communication is key to better coordination and integration.

Improving communications is central to better coordination and integration. System partners need to do a better job at follow through to ensure that the patient's transition has been successfully achieved. The effort should be bi-directional, particularly in the case of CCAC programs where there is no guarantee of service initiation. CCAC case managers should inform those individuals who make a referral and the family doctor as to the decision and rationale for admission/non-admission and/or other services offered.

The interRAI set of tools is an effective way of communicating across the health system and can serve to integrate the entire health team and the public if consistently used and shared.

More intensive and standardized use of information technology would allow patient information to be collected and shared seamlessly, making treatment much more efficient and boosting health care system productivity.

Tracking performance at care transitions, specifically looking at patient preferences in care planning, patient understanding of health self-management, the purpose for home medications and adherence to care plans are ways that the system can evaluate the effectiveness of the impact to the community. Examining adverse events, health outcomes, innovation and patient satisfaction by LHIN, regardless of setting of care, shifts the emphasis to a truly integrated responsibility and accountability to the community.

Every effort must be made to inform and support families to become knowledgeable about the various services available.

Rethinking Service Options

Providing full disclosure about all service options including those that are publicly and/or privately funded. Too often families report not being aware of the opportunity to purchase service to top up care and/or pursue other home based options prior to committing to institutional care. The public system cannot cover every eventuality and families accept responsibility for the care of their own. Every effort to inform and support families to become knowledgeable about the various services that can help them must be made.

The engagement of the family caregivers and service provider organizations that provide health care to individuals outside of the publicly funded and administered system offers the opportunity to better understand the person's needs and preferences. Health system providers need to consider the broad spectrum of health and community support services (private and publicly funded) that keep people independent and at home.

[45] Hollander, M., Chappell, N. (2002)
[46] VanderBent, S. (2004) Key Quality Processes and Outcome Measures. The Ontario Home & Community Care Council.

This mind-set should be supported at the Ministry and LHIN levels and require that the scope of LHINs to fully engage its community partners be broadened. For example, the LHINs should work with ancillary providers, non-transfer payment providers and community wide initiatives that support improved well-being of the citizens in their catchment area. With the increasing incidence of chronic disease, it is essential that health planning extend beyond traditional service provider boundaries.

Meeting the Needs of Care Recipients and Family Caregivers

The role of family caregivers has become increasingly important in society as the population ages and more people with chronic diseases and/or conditions related to aging choose to receive care at home. Family caregivers are key to the success of Ontario's home care program. Family and friends assume an estimated 80% of care that is provided to the ill, frail and dying at home.[47]

Family Caregiver Contribution

Family members are called upon to perform tasks such as wound dressings and injections, delegated by the health care professional; personal care such as bathing, dressing, eating or toileting; support activities such as preparing meals, household management, managing medication or attending to finances; and, activities such as coordinating the myriad of services that care recipients may require.

While caregiving is a positive experience for many, more than one in four (22%) showed signs of distress, including anger, depression, being overwhelmed and unable to continue providing care.[48]

Families with the means may retain home care service provider organizations to deliver additional hours that supplement publicly funded care. This care may be paid by privately-insured plans and/or direct private purchase. Home Care Ontario estimates that 150,000 Ontarians purchase an additional 20 million visits/hours of home care services annually in order to remain at home.[49]

Estimates indicate that it would cost an addition $9.7B per year to reimburse families and friends as employees for their caregiving service. Families typically want to care for loved ones and would not expect this level of compensation. However, better acknowledgement is required.

Access to Public and Private Service

The growth of home care programs and services must be accelerated to address client need and preference, and to better support family members who provide the majority of the care. Increased respite care is required. As stated previously, investment in planned respite that addresses the caregivers' needs and acknowledges their importance to keeping our elders at home is critical to ensuring the sustainability of the caregiver role.

A schedule of investment increases in home care service needs to be established so that as

[47] Fast, J., Niehaus, L., Eales, J., & Keating, N. (2002a). A profile of Canadian chronic care providers, submitted to Human Resources & Development Canada

[48] Change Foundation (2011) Facing the Facts. Do we know about families and friends taking care of Ontario's palliative home care clients? Retrieved from: http://www.homecareontario.ca/home-care-reports/other-home-care-publications/family-caregiving

[49] Ontario Home Care Association, (2013) Private Home Care – A Vital Component of the Health Care System in Ontario. Retrieved from http://www.homecareontario.ca/docs/default-source/position-papers/position-papers/private-home-care---a-vital-component---oct-2013e81a79fdc99c68708e32ff0000f8dac8.pdf?sfvrsn=10

the population ages, the amount of publicly funded home care rises. A funding formula should be created that defines that which the public system will provide to that Ontarians can anticipate their requirements they plan for their own future needs and those of aging family members.

Family caregiving, as a social norm, will be enhanced if families are provided greater support to maintain their natural and desired caregiving role including access to quality privately purchased care. Helpful incentives that government could introduce include:

- savings vehicles that incent Ontarians to set aside funds to meet their needs for care at home as they age;
- HST exemptions, and tax credits for privately purchased home care will help.

Responsive Service

Families are better served when the service provider organization whose staff is providing direct care at the bedside has greater autonomy and flexibility at the direct clinical care service delivery level. For example, service provider organizations must have the authority to manage the timing of service visits and the type of personnel assigned in order to accommodate client's preference and need and achieve expected outcomes.

Broaden system thinking about access to care

As previously stated, the CCACs, as the navigator and administrator of community-based programs, must be transparent about all the service options that are available. They need to understand the full range of services that are available prior to initiating admission to a long-term care facility.

Use of Technology

Investments in home care must include funding for testing and adoption of new technologies and innovative practices. Innovation labs within home care need to be created so that ways of leveraging technology to support individuals to continue to live their lives at home can be developed. Examples include incentives for individuals to install components of "smart homes"; support for providers to conduct virtual visits; establishment of the electronic health record. These solutions are needed so that individuals and their families can feel confident that they are supported at home and can access the health provider to resolve care needs in a timely and effective manner. This will be increasingly important in order to meet the demand within a shrinking health human resource pool.

It is time to move to bundled-payment for patient populations based on evidence, best practice and established performance metrics.

Innovation to Maximize the Value of Home and Community Care

The current funding model is out-dated and assumes the need for extensive oversight when the real world approach includes access to evidence based practice and evaluation based on regular monitoring of clinical and client satisfaction parameters.

Modifying the reimbursement model for home care services will augment the successes in the home and community sector. With the foundational contractual work completed and quality metrics established, it is time to change from the primary use of the fee-for-service payment model to bundled payment for patient populations based on evidence, best practice and established performance metrics.

This change will be most successful when coupled with the streamlining of case management roles and the devolvement of clinical decision-making to service provider organizations. This in turn would enable the shift from hundreds of billing rates established by CCACs as a means of containing costs through the old RFP approach. A component of the streamlining involves shifting the CCAC function from micro bureaucracy to audit controls where the assumption is that the service provider organizations processes are accurate and reliable. This would reduce the extensive amount of reconciliation to prove each activity, visit, and/or supply order. Home care staff should be trusted and their reports accepted as accurate.

Simple but important concepts include:

- Implementing greater consistency of administrative practices across CCACs to reduce provider overhead costs
- Collaborating on the purchase of equipment and supplies across CCACs and with service provider organization input
- Technology to enable remote monitoring / virtual visits and to leverage and enhance the capacity of the home care system. For example:
    - Point of care documentation with system linkages to enable timely access by team members, including the client and family, to relevant care information
    - Remote monitoring to access experts for clinical consultation (for example, wound management), to allow for virtual visits by members of the team
    - On site devices and systems that trigger alerts thereby mitigating risks.
- Facilitating service provider organization / hospital integration for routine, predictable patient populations (e.g. hip and knee replacements) so CCAC case management can be dedicated for patient navigation support of people with very complex needs.

Quick Wins

Conclusion

Ontarians are fortunate to enjoy a high quality of life as they age. Much has been accomplished in policy and in practice to enable seniors to live at home as long as possible. However there is more to be done. Home Care Ontario believes that there must be a willingness to examine current practice, test new approaches and undertake rigorous evaluation that addresses specific outcomes related to system utilization, cost, clinical status and most importantly, the quality of life for the elderly in society.

The work of the Home and Community Working Group is critical to continuing the development of the sector. Home Care Ontario urges continued examination of processes through the lens of 'home first' so that care choices are always based on the assumption of home as the preferred place of care. New indicators to evaluate the full cycle of care, 'system shift indicators', will be required to change the paradigm. Research in home care needs to continue to be strengthened and encouraged. The establishment of a Centre for Quality and Research specific to home care is essential. This entity would provide system stakeholders with more information in order to understand the best mix of services, administrative structures, programs and settings to achieve the greatest outcomes for individuals and the best risk management and return on home care investment for the public.

Appendix 1 – Home Care in Ontario

The Ontario Home Care Association (OHCA) advocates for the creation of a strong, reliable and accessible home care system which fully supports Ontarians to remain independent at home for as long as possible. Home care is critical to supporting individual health needs, managing chronic illness and system sustainability. A robust system incorporating both publicly and privately funded home care services can give Ontarians flexibility and independence as they age; and can help them to maintain their valuable contribution to communities and families. For the overwhelming majority who prefer to remain in their community, home care service is more desirable, cost effective and health effective.

Home care was formally established in Ontario in 1970. Since establishment, the home care system has gone through a number of changes, evolving and maturing to the comprehensive program of today. As has been the case ever since the inception of the publicly funded home care system in Ontario, service provision is based on a private sector delivery model where the corporate status of service provider agencies is varied. Ontario's publicly funded and privately purchased home care programs are vital to sustaining the publicly insured health system by enabling early discharge of patients from hospitals, reducing hospital congestion and non-acute emergency room visits – two key health care issues that currently challenge the province's health system capacity.

Publicly funded home care services are designed to complement and supplement, but not replace, the efforts of individuals to care for themselves with the assistance of family, friends and community. A fundamental component of home care is that family and/or friends will provide care to supplement the publicly funded service. Home care service providers are often contracted to deliver additional hours that supplement publicly funded care. Frequently, this care is paid by privately-insured employment plans and/or government programs (such as respite programs) and/or direct private purchase.

Home care services are intensely personal and provided at a time when individuals are most vulnerable. As such, home care providers carefully recruit, educate and support their staff emphasizing a strong customer service orientation.

Home care in Ontario, both publicly and privately funded, is a vital component of the health care system and integral to the broader health system transformation in the province. Home care research indicates that people want to remain at home for as long as possible and families will try to find ways to ensure that loved ones can maintain independence.

The OHCA works collaboratively with health system stakeholder to create seamless transitions within and across publicly and privately funded providers of health care. To do otherwise is to compromise health outcomes for those for who need support and want to remain at home.

Appendix 2 - Trends in CCAC Services[50]

Apr 1 to Mar 31	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Individuals Served:	603,535	616,952	637,727	653,730	699,020
Client Age: Age 65+	54%	56%	56%	58%	58%
Age 19-64	30%	28%	28%	27%	32%
Age 0-18	16%	16%	16%	15%	10%
Clients Placed in Long-Term Care Homes:	26,367	25,761	26,589	25,890	26,374
Full-Time Employees (approx.):	5,603	5,701	6,052	6,220	6,627
Services					
Total Units	29,419,559	29,821,293	32,806,689	34,473,802	37,991,053
Personal Support/Homemaking Hours:	20,358,189	20,965,448	23,349,790	24,926,360	27,719,897
Total Nursing	7,697,234	7,606,320	8,149,821	8,241,067	7,980,381
Nursing Visits:	5,962,097	5,799,127	6,172,865	6,135,730	5,713,359
Shift Nursing Hours:	1,735,137	1,807,193	1,976,956	2,105,337	2,267,022
Occupational Therapy Visits:	506,154	482,051	513,290	521,497	553,209
Physiotherapy Visits:	483,163	426,690	444,054	435,521	705,052
Speech-Language Therapy Visits:	251,740	242,998	245,782	250,147	263,571
Dietician Services Visits:	52,877	45,384	47,954	48,681	49,014
Social Work Visits:	70,202	52,402	55,998	50,529	52,542

[50] This chart is based on the information at http://www.homecareontario.ca/home-care-services/facts-figures/publiclyfundedhomecare.

Sue VanderBent, CEO
Email: sue.vanderbent@homecareontario.ca
www.homecareontario.ca