Submission to WSIB Rate Framework Reform

The Home Care Perspective

October 2015

HOME CARE ONTARIO

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Introduction

Home Care Ontario members are committed to ensuring health and safety at work and to reducing the occurrence of workplace injuries and occupational diseases. However, in a recent survey of home care members, 71% reported that current WSIB decisions do not reflect a clear understanding of the home care sector as a place of work. In this regard, Home Care Ontario sees the Rate Reform Review as an excellent opportunity to highlight some of the issues inherent in the special nature of home care service delivery. These issues require more in-depth consideration in both WSIB policy and practice. This paper provides an overview of home care service provision in Ontario and commentary on the proposal to discontinue the Second Injury Enhancement Fund (SIEF) as Appendix 1.

Home Care Ontario Membership Contingent on WSIB Certification

For the purposes of this response, it is critical to note that Home Care Ontario members are required to provide evidence of WSIB certification in order to be approved as a member of the Association. As the concept of the "home as a workplace" has dramatically evolved over the past 20 years, institutional parameters cannot, and must not, be applied to the community. It is clear that special attention needs to be paid to the workplace insurance issues in this emerging and fast-growing sector.

Home Care Ontario Recommendations

The Rate Reform Review is an opportunity to highlight the special home care circumstances, which require consideration in WSIB policy and practice. Home Care Ontario suggests that WSIB:

- Acknowledge home and community care as a unique setting of health and social care and consider convening a group to examine sector specific workplace issues, and the potential of a sector specific compensation strategy. This strategy could include a combination of self-funding and subsidization by government and draw on elements from the WSIB's proposed reforms such as the establishment of risk bands based on a hybrid of claims cost and accident frequency.
- Provide more information about how future determination of rate banding or classification.
- Retain the Second Injury Enhancement Fund (SIEF), which is discussed at Appendix 1.

Background

About Home Care in Ontario

Home care is defined as an "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".[1] A summary of the history and evolution of home care in Ontario is at Appendix 2.

Home care is delivered by service provider organizations (SPOs) that meet high standards of excellence, many of which are reported publicly by Health Quality Ontario (HQO).[2]

[1] Canadian Home Care Association
[2] See http://www.hqontario.ca/Public-Reporting/Overview

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 services are intensely personal and provided at a time when individuals are most vulnerable.

Unique to home care service delivery is that it is provided in the patient's home, and family and/or friends provide the majority of care. As guests in the patient's home, the SPO staff manages the delicate balance of creating a safe working environment and providing safe care for patients while respecting their individual rights within their own homes. SPO staff demonstrates flexibility, autonomy and excellent problem solving skills in working effectively in an unregulated environment that is controlled by others and that was not designed as a place for health care service provision. While supplies and equipment can be brought into the home and families will typically do their best to accommodate the requirements for care, the reality is that the home setting has limitations as a place of safe care.

Delivering Safe Care at Home

Innovation and creativity are crucial in home care where the 'work environment' is indeed someone's home. When delivering home care, all providers understand that the control is, to a much greater extent, on the client's terms. Each new client environment poses potentially new and different challenges for the home care provider and can create an element of unpredictability for staff. In order to address occupational health and safety issues, it is imperative that the context of care be well understood.

Visits

Whether privately or publicly funded, home care services are paid on a per unit (typically per hour) basis. Not surprisingly, demand for service is greatest at the start and end of the day, necessitating a large 'casual' pool of staff and split shifts. In the government program, there is increasing emphasis on "time for tasks" with the expectation that some services will be completed within 15-30 minutes. Staff must be adept at conducting assessments, completing tasks and problem solving quickly.

Time for tasks, such as an allotment of 15-30 minutes to help a frail 80 year old up in the morning or go to bed at night leads to increased risk of injury to the employee and/or the patient – particularly when coupled with the challenges of the home environment.

Travel

Travel between clients is typical. Staff are therefore impacted by severe weather conditions, whether walking, using public transportation or driving their own vehicle.

Redeployment of staff

Clients have the right to change the time of their services and request a different staff to provide their care. Demands in the home may result in frequent changes in order to accommodate the client and family. The staff must ensure that the client will be ready for service every day as there is generally no opportunity to return to provide service later. In fact, the public system penalizes SPOs who attempt a visit when the client is not home.

SPOs manage new admissions and discharges daily. The timing of services, needs and location of clients does not always align with the availability and positioning of staff with

the requisite expertise. Reassignment is complicated by a factor of distance not found in other health care settings.

Down time cannot be leveraged in the same way that it can in an institution. It is sometimes too far to expect staff to travel in order to complete administrative type tasks.

The home setting

"Peoples' homes, both apartments and houses, are rarely suited to the provision of safe healthcare. Homes of the chronically ill are often run down. They become cluttered, dirty and poorly maintained environments. Icy walkways, pets, halls blocked by wheelchairs and walkers, and cramped spaces with little room for treatment-related equipment are common safety hazards" for home care staff.[3] Additionally, staff may have to address issues such as removal of safety hazards such as scatter rugs; smoking in the home[4]; safe care and management of equipment; and the need for access to proper hand washing stations, approved cleaning products and receptacles for waste, including sharps.

> Working in cramped settings without lifting and transfer equipment or assistance, for example, contributes to increased risk of injury.

As guests, workers, in the patient's home, SPO staff defer to the person's direction on all matters – ranging from basic household maintenance to timing of service and the people (and sometimes animals!) that are present. Staff considers each person's values and preferences in delivering care. SPOs carefully recruit, educate and support their staff emphasizing a strong customer service orientation.

Working alone

Working alone can provide staff with a sense of autonomy found nowhere else within health care and yet staff may be exposed to unwelcoming environments.

A judgment call

Notwithstanding the support provided to staff, there are challenges to delivering care and maintaining the integrity of the home. Mitigating risk is a judgment call by the funder, SPOs and their staff.

In extreme situations, SPOs can withdraw service if compliance to expectations is not achieved. However, a key metric by which SPOs are measured is their ability to achieve the client's goals and objectives. And, more importantly, SPOs and their staffs are highly motivated to find the solutions that balance the health care agenda with the person's way of life.

A system of compensation for home care workers

The current WSIB system has evolved over time and the approach for home and community care could be enhanced. Home Care Ontario suggests that now is the time to engage in dialogue with an expert group on the merits of a home care sector specific plan and the various approaches that could be taken to administer, finance and oversee its implementation.

[3] Canadian Patient Safety Institute p18
[4] Despite Ontario's legislation

By understanding the sector specific injuries in conjunction with the risks factors for occupational health and injury to staff delivering care in the home, stakeholders will be better equipped to develop innovative mitigation strategies that are practical, realistic and respectful of the client as steward of his home and the worker who must be assured a safe working environment.

Stakeholders will be positioned to understand the value of various technologies to the rate and nature of staff injuries, leading to improvements in guidelines that address the occupational risks for care in the home.

Conclusion

Ontarians want to receive care at home, a shift that is being adopted by the health care system and supported by families, who provide the majority of care at home. The challenge is to avoid simply moving institutional based systems to the home and community care sector. Home care worker compensation needs to be examined and "reset" in order to remove the legacy of facility practices and costs.

Home care service provider organizations have developed new safety approaches that respect clients and staff and the unique (for healthcare) setting of service delivery. By managing costs independently, the province will have a means of learning about the impact of shifting care to the home on staff safety and will be able to understand the effect of tools and policy development.

Given the evolution of home and community care and the critical role of the sector to address the health care needs of the aging population, the Association believes that it is time to examine the approach to worker injury compensation.

APPENDIX 1: Elimination of the Second Injury & Enhancement Fund (SIEF)

Home Care Ontario does not support the discontinuation of SIEF. The members of the Association believe that if employers are denied the option of applying for SIEF as a means of cost reduction, the WSIB should expect substantially more employer appeals of initial entitlement and use of the recently introduced policy Aggravation Basis policy (Policy 15-02-04, effective November 2014) as a basis for their appeal.

Background

As described in Policy 14-05-03, SIEF has two objectives:

1. To provide employers with financial relief when a pre-existing condition enhances or prolongs a work-related disability, and,
2. To thereby encourage employers to hire workers with disabilities.

Providing financial relief to employers where some portion the employer's claim costs arise from conditions unrelated to the workplace injury is expressly part of the SIEF's policy objectives.

Paper 3 indicates that the justification for SIEF will be removed by the predictability of premiums and the limitation on annual movement between risk bands in the proposed system. While these are laudable objectives, they are unrelated to SIEF. Employers apply to SIEF to lower their costs, not to make them more predictable or consistent.

Maintaining SIEF in the proposed framework will serve the same purposes it always has. It will reduce employers' costs of claims, where the claims are prolonged for reasons unrelated to the accidents giving rise to the associated WSIB claims, and provide an incentive to employ, and continue to employ, injured workers.

Mis-use of SIEF

Many of the objections raised in Paper 3 to SIEF arise not from the program itself, but rather from abuses or potential abuses of the program. In particular,

1) SIEF costs are increasingly being applied after the experience rating window closes,
2) Some employers request SIEF in 100% of their lost time claims,
3) Some employers, predominantly larger ones, make "excessive resort to SIEF to reduce their claims costs", and
4) Some employers "may" be investing more in SIEF than in prevention.

1) Experience Window Closing - These concerns must be considered in the context of the WSIB appeal process. The extreme delays in the WSIB appeal process, particularly as relating to obtaining file access and scheduling WSIAT hearings, are driving many appeals, including SIEF appeals, beyond the experience rating window. Addressing appeal efficiencies would be a more appropriate means of dealing with this delay issue than cancelling substantive rights. The WSIB would never consider denying benefits to a worker because their appeal took more than four years to reach a final conclusion. The same rationale should apply to any substantive rights in the Act or Policies. Furthermore, the extension of the window from the current four years to the proposed six years would largely reduce this problem.

2) 100% of Lost Time Claims - Employers who seek SIEF relief in 100% of their lost time claims, are clearly abusing the Fund. However, that abuse may arise not from a desire to

truly obtain SIEF (although that is a secondary objective), so much as a desire to obtain a copy of the worker's WSIB file and learn what is actually happening in the claim. Employers only gain access to the information in a worker's WSIB file by launching an appeal; any form of appeal. Launching a SIEF appeal, even where there is admittedly no hope of success, allows an employer access to the WSIB claim file. Commencing a legitimate SIEF appeal for every lost time claim would be counter-productive and not cost-effective for an employer. But as a means to obtain the WSIB file, a SIEF application, with or without any hope of success, is an effective tool.

3) Excessive Resort - Regarding "excessive resort to SIEF" by large employers, if the WSIAT and ARO's are granting the requests for application to SIEF, then the resort to SIEF cannot be excessive. If relief were not warranted, it would not be allowed in those cases. The observation that larger employers use SIEF more than smaller ones is not an inherent flaw with SIEF itself, so much as a shortcoming in awareness in the smaller employer community of its existence, the lack of earlier decision makers in granting SIEF where it is evident to do so or the challenges inherent in the appeal process that makes such appeals too hard for smaller employers to manage. As with the other concerns, the problem is not with SIEF itself, but rather with awareness, the earlier application of, and the appeal processes associated with applying for SIEF.

4) Prevention - As regarding employers potentially investing more in SIEF than accident prevention, the concern seems misplaced. At most, a SIEF application is a speculative exercise by an employer, with the prospect of reducing only some percentage of the cost of a claim. Prevention would eliminate those costs completely, and with certainty. Only the most misguided of employers would see SIEF as a superior means of cost containment as compared to prevention.

Conclusion

If employers are denied the option of applying for SIEF either as a means of cost reduction or obtaining WSIB file access, the WSIB should expect substantially more employer appeals of initial entitlement. At present, an employer might not appeal an initial entitlement decision, and allow the worker to obtain benefits uncontested, secure in the knowledge that if the claim is prolonged despite the best return to work efforts of both parties, the employer can apply for SIEF to obtain the file, review the medical information, and pursue an appeal to reduce its costs if such appeal is warranted. In the absence of SIEF, that same employer would have a much stronger incentive to appeal the initial entitlement decision at first instance. The elimination of SIEF will likely result in more appeals, rather than less.

APPENDIX 2: History of Government Funded Home Care

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.

Government funded home care was formally established in Ontario in 1970 and has grown and evolved as a sector over the past 45 years. 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. Today, the government funded home care system is responsible for providing almost 38 million visits/hours of high quality care at home to close to 700,000 Ontarians per year.[5] As the largest home care program in Canada, Ontario leads the way in building a system driven by quality and evaluated on several dimensions.

In Ontario, the publicly funded home care program is locally administered by 14 Community Care Access Centres (CCACs) across the province.[6] CCACs are accountable to the Local Health Integrated Networks (LHINs), regional organizations responsible for local health system planning, community engagement and funding a wide range of health service providers. 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[7] 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.[8]

Family's Role

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. Families are the mainstay of the home care system – only 2% of clients manage without a family caregiver.[9] Family caregivers provide 80% of care at home and many choose to privately retain support in order to cope with the challenges of work, family and distance to a person in need of care. Without family caregivers, government funded home care, as it is currently configured, would not be a feasible option.

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[5] MOH Health Data Branch Web Portal. Analysis of 2013/2014 YE 2013/2014 YE reports.
[6] 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
[7] 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
[8] Canadian Home Care Association, p80
[9] Canadian Institute for Health Information, p1

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.[10] Privately purchased home care service often provides the vital few hours of care and respite that enables families to continue their caregiving responsibilities while fulfilling their other obligations such as raising their children and holding a job. This privately retained service often supplements the publicly funded care. For some, the care may be paid by privately-insured employment plans. For most, the care is an out-of-pocket expense.

Family caregiver is the term used to denote a family member, friend or family of choice who gives unpaid care to someone, either at home or in a facility, who has a physical or mental health condition, or is chronically ill, frail, or elderly.[11] The use of the term "informal caregiver" is discouraged because, to many caregivers, it diminishes and invalidates the role and the nature of the care they provide.[12]

Why Home Care?

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.[13] One of the most significant and least desirable outcomes for a community dwelling senior is to be prematurely institutionalized[14] because of the lack of home and community care based health and social support options.

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 provide Ontarians flexibility and independence as they age; and can help them to preserve their memories and contributions to their communities and families. For the overwhelming majority who prefer to remain in their community, home care services are most desirable, cost effective and health effective.

Future Directions

The shift to care at home will continue. Ontarians want to remain at home as long as possible. Clinicians agree that outcomes are often better at home. And politicians recognize that health system value is improved with a robust home care system, which relies on family contribution. As the home care sector grows and evolves to respond to the demands of the system, there is a need for legislative and regulatory change that reflects the setting. The challenge is to balance the unique attributes of home care while ensuring safe and effective care for the client and a safe experience for the staff in the providing of that care.

[10] Ontario Home Care Association. (2009) Creating an Ontario Home Care Rebate to Prevent Additional Costs to the Frail and Vulnerable
[11] Caregivers Nova Scotia
[12] Caregivers Nova Scotia
[13] Rowe, J. W., & Kahn, R. L.
[14] 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.

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