Capacity Planning

The Home Care Perspective

Home Care Ontario

April 2016

Overview

The Government of Ontario is proposing significant structural change to the foundation and operation of the health care system. Home care is a central to the transformation that has been launched and the sector has been invited to offer insight to enhance health system capacity planning and ultimately better meet the needs of the population.

Members of Home Care Ontario currently serve Ontarians as contracted providers to the Community Care Access Centres (CCACs) or as the Home Care Providers privately retained by Ontarians to supplement the services that are funded and authorized by the government. Home Care Providers are accountable for direct clinical care at the frontline, for clinical expertise and evidence-based practice, risk, performance and quality management and patient outcomes.

Ontarians are generally unaware that the current capacity of the health care system to provide home care is directly impacted not only by funding available but also, to a great extent, the availability and ability of the family to provide care. As a result Ontarians are often, understandably surprised and critical of the limitations of the publicly funded system.[1] [2] Leadership is required to clearly define the limitations and parameters of the health care system. People will generally adapt and cope once they understand the scope of home care service. It is the inconsistencies and service limits that cause people to assume that the system is underperforming. Public education about what is truly equitably available is therefore an important first step to system capacity planning.

Having established the mandate and true scope of the system, consistent standards and implementation that allows a reasonable range of flexibility in response to patient need (as opposed to system requirements) is critical.

Finally, the effectiveness of the system as experienced by the patient and family must be measured and publicly reported creating the opportunity for improvements and more education. Relentless cycles of improvement and education are required, to realize the goals of an integrated approach to health care, which includes home care.

Home Care Ontario offers insight and concrete recommendations as to the many ways in which a robust home care can effectively enhance the capacity of the broader health care system and how the home care system can be enhanced to the benefit of all Ontarians.

[1] Donner
[2] Lysyk p6, 37

How A Robust Home Care Can Effectively Enhance The Capacity Of The Health Care System to Keep People at Home [3]

System Goals	Evidence	Home Care Contribution
Right Care, Right Place, Right Time, Right Provider ***With the premise that home is preferred***	↓ALC ↓Inappropriate use ER ↓Premature LTC placement	*Planning* • Proactive interventions – evidence based, e.g. medication management, exercise, wellness checks, meals, transportation • Pre-op preparation that links to the discharge plan *Responsiveness* • Time limited intensive home care resources to support transitions home &/or through a crisis – of health or family caregiver • 24x7 access to care – admission, treatment, service, e.g. telephone support; mini-assessment; remote monitoring of clinical state (ECG, BP, O2 sat) • EMS support in the home for crisis intervention *Caregiver Support* • Home-based respite for family caregivers • Financial relief for family caregivers – refundable tax credit; HST relief *Team Based Care* • Interdisciplinary collaboration – funding for physician or pharmacist consultation; funding for team based meetings • Improved documentation sharing – access to client record seamlessly 24x7 *Clinical Autonomy* • Clinician determined mix, timing, length and frequency of services – evidence based, e.g. pathways, client need • Clinician authorized equipment and supplies • Clinician determination re new treatment approaches *Standards* • Standardized admission and service criteria and delivery administered by the provider professional • Province wide consistency of standards, codes, IT systems, reporting requirements • Equitable availability of service, supplies and equipment for all Ontarians across the continuum of care *Education* • Consistent, clear & transparent information about the true amount of home care resources (public & private) that are available, including the means to contact an advocate / ombudsman – publicly promoted; available through all system providers; and required to have been reviewed with family prior to a placement decision *Human Resources* • Highly qualified staff whose compensation is commensurate with others in the health system and who can access continuous education and development *Research & Evaluation* • Research to support evidence-based practice • Monitoring and reporting in order to spread successes and provide opportunities for learning

Realized through trust & confidence in the system by empowered patients & staff

[3] VanderBent (2013)

Enhancing the Capacity Home Care System

Home Care Contribution	Initiatives/Actions	Impact 🡻ALC 🡻Inappropriate use ER 🡻Premature LTC placement
Planning • Proactive interventions – evidence based, e.g. medication management, exercise, wellness checks, meals, transportation • Pre-op preparation that links to the discharge plan	• Leverage the synergy between home care and community services • Facilitate service provider organization / hospital integration for routine, predictable patient populations (e.g. hip and knee replacements)	• Avoid / delay the need for additional health care • Maximized independence at home • Reduced isolation • Shift away from reactive model to one that is better suited to an aging population
Responsiveness • Time limited intensive home care resources to support transitions home &/or through a crisis – of health or family caregiver • 24x7 access to care – admission, treatment, service, e.g. telephone support; mini-assessment; remote monitoring of clinical state (ECG, BP, O2 sat) • EMS support in the home for crisis intervention	• Shift from predefined service limits, visit times and defined tasks to one that is responsive to the person's rights, needs and wishes • Coordinate care for family when more than one member is receiving service • Establish a schedule of investments in government funded home care • Introduce flexible policy to enable increased service • Reimburse virtual visits – remote monitoring, telephone interventions	• Increased home care costs • Increased patient QoL • Increased appropriate resource utilization • Increased numbers of durable discharges[4] • Increased amount of publicly administered home care aligned to aging population. • Increased client-centred service • Improved access to experts for clinical consultation (e.g. wound management, clients in remote settings) • Increased triggering of alerts thereby mitigating ER Presentations and ALC • Remote monitoring helping to meet demand within a shrinking health human resource pool • Sustained service levels 24x7 52 weeks per year • Increased client and provider confidence and trust in the system
Caregiver Support • Home-based respite for family caregivers • Financial relief for family caregivers – refundable tax credit; HST relief	• Increased funding for respite • Provide family counselling and mental/emotional health support • Establish programs to motivate family caregiving friendly policy & behaviours	• Sustain the family caregiver • Avoid premature institutionalization • Decreased caregiver stress, distress and poor health • Acknowledgement of caregiver contribution

[4] A discharge plan that provides the client and family with the tools to manage successfully at home.

Home Care Contribution	Initiatives/Actions	Impact 🡻ALC 🡻Inappropriate use ER 🡻Premature LTC placement
	amongst employers. • Encourage senior friendly communities	
Team Based Care • Interdisciplinary collaboration – funding for physician or pharmacist consultation; funding for team based meetings • Improved documentation sharing – access to client record seamlessly 24x7	• Encourage multiple services from one provider • Fund client care rounds in the community • Introduce billing codes for consultations • Fully implement operating systems across all providers in the province starting with home care and primary care	• Increased consistency • Less duplication of service by multiple providers • Respect for the training and ability of team members • Smoother transitions because of better communication
Clinical Autonomy • Clinician determined mix, timing, length and frequency of services – evidence based, e.g. pathways • Clinician authorized equipment and supplies • Clinician determination re new treatment approaches	• Decrease micro management of clinician & introduce audit controls • Phase out duplicative clinical service provision[5] and reposition with Home Care Provider • Standardize equipment & supplies and increase the number of clinicians who can approve / authorize • Bundled payment for patient populations based on evidence, best practice and established performance metrics.	• Assumption that Home Care Providers and their staff have accurate and reliable processes • Greater role clarity • Decreased costs and redundancies • Improved client satisfaction • More responsive service delivery • Increased client satisfaction • More innovation in care delivery
Standards • Standardized admission and service criteria and delivery administered by the provider professional • Province wide consistency of standards, codes, IT systems, reporting requirements	• Develop a short standardized admission assessment tool – a short assessment prior to service initiation and a longer one for outcomes based planning • Standardize service codes • Develop standard definitions	• Decreased waiting for service • Simplified billing and payment process • Eliminate additional coding and processing expenses • Less administrative time required • A broad understanding of the impact of policy, funding and service delivery approaches • Would help government and health care administrators to prioritize spending.
Education • Consistent, clear &	• Educate Ontarians about the	• Empowered people who are

[5] Lysyk, p6, 37

Home Care Contribution	Initiatives/Actions	Impact 🡻ALC 🡻Inappropriate use ER 🡻Premature LTC placement
transparent information about the true amount of home care resources (public and private) that are available, including the means to contact an advocate/ombudsman – publicly promoted; available through all system providers; and required to have been reviewed with family prior to a placement decision	need for a Personal Aging Strategy and the need to save for home care services in order to remain at home later in life. • Equip providers with key messages about the home care system.	better informed and prepared regarding their options. • Providers feel more confident about the expectations that are set. • Improved access to home care (private and public). • Increased home care capacity.
Human Resources • Highly qualified staff whose compensation is commensurate with others in the health system and who can access continuous education and development	• Decrease the wage gap in home care professional services • Fund continuing education and career advancement opportunities • Resist prescribing employment parameters	• Demonstration of the importance and value of home care service provision • Ability to leverage skills and expertise of the worker who wants part-time hours e.g. student, parent who wants to supplement income, people moving toward retirement • Facilitates consistency and responsiveness to the peak demand hours
Research & Evaluation • Research to support evidence-based practice • Monitoring and reporting in order to spread successes and provide opportunities for learning	• Stop the extensive oversight and shift to evaluation based on regular monitoring of clinical and client satisfaction parameters. • Public reporting of outcomes • Institute provincial benchmarking	• Objective means of evaluation driving best practice

Discussion

Defining the mandate and scope of health care, including home care, is both complex and simple. However, once defined, the providers must work within the established mandate and be assessed according to system and individual client goals.

Person-centred Approach

There is no question that home is where patients and their families would prefer to be and that most families expect to provide support when a loved one needs care. In addition to improved quality of life, care at home decreases the risk of infection and increases the likelihood of ambulation and socialization – both of which are required to support recuperation.

Most importantly, a person-centred approach is fundamental to the home care philosophy. The

person's home as the setting of care has a significant influence on the balance of power between the health care provider and the recipient. Home care providers recognize therefore, the need for flexibility and autonomy within a well-defined and consistent system of care. Judgment is crucial and health care providers, individually and as members of an organization, must be accountable for their decisions within a clear framework.

Families are the mainstay of the home care system – only 2% of clients manage without a family caregiver[6]. Family caregivers provide 80% of care at home, supplementing the government-funded service. The average family caregiver spends twenty hours per week caring for a period of four years; one quarter of caregivers spends forty hours per week.[7] Without the contributions of family caregivers, there would be an increased risk of institutionalization[8], which is both costly and socially unacceptable to Ontarians.

Families typically expect to provide care to their family at home. However without knowledge about what the health system can and should provide, families are unprepared, misinformed and ultimately may feel robbed of an entitlement. This problem is exacerbated when health providers have conflicting opinions about what the system can do and when they operate differently across the province.

Population Health Needs

The health system addresses the needs of people of all ages. In home care, the majority of service is provided to individuals who are 65yrs and older. With the shifting demographics, the number of seniors is increasing and by 2036 will more than double from 1.9 million to 4.1.[9] The oldest age groups, and typically those that are most frail and in need of the most support from families, are increasing most rapidly with the 75plus group projected to grow by approximately 144 percent by 2036 and the 90plus group to triple in size.[10] The ballooning dependency ratio will challenge the ability of both the health system and families to respond.

The current bureaucracy within the home care system causes families to turn to primary care or hospital care when they can no longer cope. Service approvals should be fast, focused, flexible and friendly. Patients and families, who provide the majority of care at home, need timely support in order to sustain the tenuous balance that often exists when illness presents. A call for home care should result in service until a formal assessment can be conducted and a plan of care undertaken.

Standardization of practice can reduce errors and provide the means for improved practice and outcomes. Over the past decade standardized care plans and outcome-based pathways have been developed in home care for conditions such as wound, and total hip and knee replacements. While the complexities of the senior population make the application of care pathways difficult, the work on care pathways should continue. Additionally standardization of administrative processes must be adopted.

Common Objectives

At the highest level, the objective that all health care providers share is to return people home and to the best health state possible. The realization of this objective can be achieved by a system that rewards the stated outcome over the full episode of care. This requires trust and collaboration at all levels throughout the health care system.

---

[6] Canadian Institute for Health Information, p1
[7] Ministry of Health and Long-Term Care, p6
[8] Canadian Institute for Health Information, p1
[9] Ontario's Seniors' Secretariat, p5
[10] Ibid.

Current home care measures provide information about the home care delivery process. However, process metrics can result in too little attention on patient outcomes. Just as in all areas of health, the best metric is the patient outcome over the course of a care episode.[11]

This would contribute to increased flexibility within standards of care to 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. For example, they may 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.[12] 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.

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.[13] 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.[14]

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.[15] [16]

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.[17] [18] [19] [20]

The common objective of keeping patients at home provides the framework for shifting resources to provide the right care at the right time and place.

Approaches / Models to Health Care Delivery

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.

[11] Porter
[12] Oral report. (October 2014) Situation reported by a palliative care nurse in a focus group session.
[13] VanderBent (2010)
[14] Ibid
[15] Canadian Home Care Association. (2012)
[16] Canadian Home Care Association. (2006)
[17] Markle-Reid (2008).
[18] Markle-Reid (2004)
[19] Hollander (2002)
[20] Hollander (2007)

Major Capacity Planning Challenges

Providing quality health care to Ontarians is a fundamental principle on which the Government of Ontario bases health care policy development. Developing the most effective approaches for defining and incenting behaviour and system change in order to enhance quality has been, and continues to be, a key challenge in Ontario and in health systems around the world.

As a sector, publicly funded home care supports more 710,000 clients with approximately 39 million hours of care every year. The draw on the province remains at 5% of the total health care budget, which has remained essentially unchanged over the past decade. Home Care Providers have a long history of maximizing capacity within their organizations and have done so through investments in education, training, technology and standards.

Home Care Providers are keenly interested in leveraging capacity in order to get more care to the client and family. As independent organizations, there are many opportunities to innovate and unleash potential. However in the broader health care system there are real barriers that must be addressed. These include:

- The health care system is designed and evaluated by sector, which limits the capacity gains at transition points.
- The cycle for change in policy and practice is longer in large organizations where there are many stakeholders to consider and approvals to be obtained.
- There is an absence of truly aligned system goals and objectives that cross all sectors within the health care system.
- The health care system measures outcomes that do not link to the goals of the health system.
- A lack of standardization – clinical and administrative, that results in extra work, redundancies, and less opportunity to compare and share best practice.
- Entrenched and misinformed beliefs about what the home care system can accomplish.
- Risk adverse leaders who are reluctant to change until the requisite policies and procedures are aligned.
- Fear of raising public expectations beyond the current home care capacity.
- A reluctance to consider home care solutions outside of the publicly funded system.

Conclusion

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 over 38 million visits/hours[21] of high quality care to Ontarians per year.

However the shifting demographics in Ontario is a call to action for all stakeholders to create a health system that is person centred and community based. Home Care Ontario believes that there must be a willingness to examine current practice, test new approaches and undertake rigorous

[21] MOHLTC

evaluation that addresses specific outcomes related to system utilization, cost, clinical status and most importantly, the quality of life for the elderly in society.

About Home Care Ontario

Home Care Ontario, the voice of home care in Ontario™, is a member-based organization with a mandate to promote growth and development of the home care sector through advocacy, knowledge transfer, and member service. Home Care Ontario members include those engaged in and/or supportive of home-based health care. In Ontario, service provider organizations are responsible for providing nursing care, home support services, personal care, physiotherapy, occupational therapy, social work, dietetics, speech language therapy and medical equipment and supplies in the home to individuals of all ages. An estimated 58 million hours of publicly and privately purchased home care service is provided annually across the province.

For more information, contact:
Susan D. VanderBent, CEO
Phone: 905-543 - 9474
Email: sue.vanderbent@homecareontario.ca

For the latest in news and information about the home care sector in Ontario, subscribe to "House Call" or follow us on Twitter.

Appendix

Initiatives to Support Capacity

A number of initiatives have been undertaken by Home Care Ontario members, many of whom have operations in other provinces and with various funders. These include:

- Leveraging human resources
  - Through cross training
  - Education, e.g. managing challenging behaviours
  - Delegation
  - Use of aides/assistants to support clinicians

- Client support
  - Coaching/teaching to enable self-management
  - Telephone check-in and follow-up
  - Population based initiatives, such as palliative care, renal care, wound care, dementia care

- Use of technology
  - Point of care documentation
  - Telephony to support staff safety, create administrative efficiency and improve client service
  - Remote monitoring of clinical parameters
  - Electronic support in the home to expert consultants, e-shift, wound specialists

- Models of care
  - Congregate settings, for example group homes, clinics
  - Transitional Care
  - Long-term Care/Nursing Home/Home Care integration
  - Hospital/Home Care integration
  - Integrated Practice Units

- Standardization
  - Assessment tools
  - Workflow processes

Works Cited

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

Canadian Home Care Association. (2006) Partnership in Practice. Ottawa.

Canadian Institute for Health Information (2010) Supporting Informal Caregivers - The Heart of Home Care. Analysis in Brief. Ottawa. https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC1533

Donner, G. (2015) Bringing Care Home, Report of the Expert Group on Home and Community Care. Toronto Ontario. Retrieved from: http://health.gov.on.ca/en/public/programs/ccac/docs/hcc_report.pdf

Hollander, M., Chappell, N. (2002) *Final Report of the National Evaluation of the Cost-Effectiveness of Home Care*, Health Transition Fund (2a)

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.

Lysyk, B. (2015) Community Care Access Centres – Financial Operations and Service Delivery, Special Report September 2015. Office of the Auditor General of Ontario. Queen's Printer for Ontario

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

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

Ministry of Health and Long-Term Care (2009) Caring-About Caregivers: Caregiving for the future of Ontario. Long-Range Scenario Planning Supporting Caregiving into 2033. Toronto, Ontario.

MOHLTC. (2015) Health Data Branch Web Portal. Analysis of 2014/2015 YE reports.

Ontario's Seniors' Secretariat (2013) *Independence, Activity and Good Health Ontario's Action Plan for Seniors.* Queen's Printer for Ontario.

Porter, M.E., Teisberg, E. O. (2006) Redefining Health Care: Creating Value-based Competition. Harvard Business School Press. Boston, Mass.

VanderBent S., Kuchta, B. (2010) Valuing Home and Community Care. Ontario Retrieved from: http://www.homecareontario.ca/docs/default-source/publications-mo/valuing-home-and-community-care.pdf?sfvrsn=4

VanderBent S., McAlister M. (2013) Can this care be provided at home? Healthcare Quarterly, 16(1) January 2013: 93- 96.doi:10.12927/hcq.2013.23325