

# Home Care

## *recommendations to support physicians and patients as they access home care services*

by OMA Health Policy Department

### 1. The Case For Home Care

THE GOVERNMENT OF ONTARIO HAS STATED THAT HOME CARE IS GOING TO BE A CENTRAL FEATURE IN HEALTH CARE MOVING FORWARD, AND IS SHIFTING CARE TO INDIVIDUALS' HOMES UNDER CERTAIN CIRCUMSTANCES. THE SHIFT TO PROVIDE MORE HOME CARE ADDRESSES GROWING HEALTH CARE COSTS, AN AGING POPULATION, AND INCREASING DEMANDS AND EXPECTATIONS FROM THE HEALTH CARE SYSTEM. HOME CARE IS NOT ONLY CONSIDERED A MORE COST-EFFICIENT WAY<sup>1</sup> TO PROVIDE SOME HEALTH SERVICES, IT IS ALSO THE PREFERENCE OF THE OVERWHELMING MAJORITY OF CANADIANS TO REMAIN IN THEIR HOMES FOR AS LONG AS POSSIBLE.<sup>2</sup> IN RESPONSE, THE ONTARIO GOVERNMENT INCLUDED HOME CARE AS A KEY ELEMENT IN "ONTARIO'S ACTION PLAN FOR HEALTH CARE"<sup>3</sup> AND "LIVING LONGER, LIVING WELL," WHICH PROVIDES RECOMMENDATIONS TO INFORM THE CREATION OF A SENIORS STRATEGY IN ONTARIO.<sup>4</sup>

#### The Physician Perspective

Ontario physicians recognize home care as a key element in the care of patients, and support shifting care to patients' homes in certain cases. For this to be effective, resources, including appropriate staffing and equipment availability, need to be addressed to ensure home care is prepared to handle the influx of patients who require care in their homes and communities.

Physicians understand that for many patients, a daily home visit from a personal support worker or allied health professional can play a significant role in maintaining their independence and their health. Physician house calls also play a significant role in home care. When physicians visit patients in their home, they are often providing care that would have otherwise been obtained

in hospital. However, there are limitations to what care can be provided in the home.

This paper provides an overview of how home care is delivered in Ontario, evidence to explore various models of care, the physician perspective obtained through consultations, and recommendations to support the integration of home care into the overall care of the patient.

#### 2. Defining Home Care

The Canadian Home Care Association defines home care "as an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end of life care, rehabilitation, support and maintenance, social adaptation and

integration and support for the family caregiver."<sup>5</sup>

Home care includes the provision of services in the home and also in the community. The definition of home care continues to evolve in response to changes that have occurred in the hospital sector (bed closures, increase in ambulatory care clinics, and day surgery) and in the long-term care facilities sector (waiting lists for beds, limited availability).<sup>6</sup> Often, home care functions "as a bridge between the various settings of care, including acute care hospitals, emergency rooms, supportive living, long-term care homes, and the physician's office. With a clearer focus on better managing chronic diseases, home care services have expanded to include health promotion and informal caregiver support."<sup>7</sup>

### The Home Care Patient

Currently, more than half (58%)<sup>9</sup> of all home care clients in Ontario are seniors, and the number is expected to increase as the number of seniors with one or more chronic diseases is also on the rise. While this is the largest group currently accessing home care, it is important to recognize that 27% are non-senior adults, and 15% are children.<sup>9</sup> It should be noted that since these numbers are based on use of the publicly funded system and do not capture the entire population of people using home care, the numbers are likely higher.

High-needs patients with complex conditions tend to be frequent users of the health care system and are having an impact on the home care sector. Complex patients have one or more chronic conditions. Among seniors, three out of four report having at least one of 11 chronic conditions, and a quarter of seniors report being diagnosed with three or more of these conditions.<sup>10</sup> However, age is just one factor and, in fact, statistics show that regardless of age, higher utilization was reported among those with a higher number of chronic conditions.<sup>11</sup>

The patient mix for home care is diverse and challenging. Patients with complex conditions are being discharged from hospital sooner and sent home with home care supports. Patients with mental illness require an increasing amount of home care services. Changing funding models in long-term care homes result in patients being admitted for short-term stays for rehabilitation and respite care, and being released back into the community requiring home care supports.

Wound care currently accounts for a significant proportion of home visits. In Canada, it is estimated that “50% of care delivered by home care programs...involves the management of wounds,”<sup>12</sup> and “more than 80% of ongoing management of chronic wounds occurs in the community.”<sup>13</sup> Due to the impact wound care is having on home care, the OMA is planning a future paper to explore this topic.

Home care also has an important role to play at end of life. While the

majority of Canadians have expressed a preference to die at home, 75% of deaths take place in hospital or long-term care homes.<sup>14</sup> Research shows that palliative care provided by interdisciplinary teams in the community is co-ordinated, appropriate and consistent.<sup>15</sup> Patients benefit from the enhanced level of care provided; physicians and other health care providers also receive support from other members of the team, which allows for better caseload management.

### The Physician Perspective

For physicians, including specialists, treating complex patients in the home can be challenging. The treating physician may be faced with complicated home visits without sufficient system support, including support staff or necessary equipment. During consultations, physicians revealed difficulty in gathering information pertaining to the availability of home care and eligibility of patients. Physicians also expressed frustration with a home care system that does not take into account the urgency for home care required by some patients, as identified by physicians. This delay in services for patients often leads to a deterioration in the condition of the patient and can lead to a preventable hospital visit or admission.

### Addressing Needs Of Complex Patients

The Toronto Central Local Health Integration Network (LHIN) has implemented a program to address the needs of older adults with complex medical conditions. According to the Toronto Central LHIN, the Integrated Client Care Project (ICCP) aims to keep homebound older adults living independently in their homes<sup>16</sup> by providing a team-based approach to care. The ICCP consists of a team of providers that includes the family physician, Community Care Access Centre (CCAC) case manager (also referred to as a care co-ordinator), a single pharmacy, and home care providers who offer ongoing support in the home. Providers engage in joint home visits, and emergency medical services are involved in care for patients who have been identified as high-risk users

of the emergency department. Patients who receive care under this project are put in contact with a case manager from CCAC, who co-ordinates their overall care and is the patient’s main contact in the health care system. Teams of providers, including a family physician, are connected through the case manager. The program is being expanded to medically complex children and palliative care patients.

A project in the South West LHIN and the South West CCAC was initiated with the goal to improve care for patients with diabetes. The Partnerships for Health three-year initiative (2008-2011) included more than 300 primary care and community care professionals in 73 practices across southwest Ontario who worked in interdisciplinary, cross-organizational teams. The goal was to develop partnerships between family physicians and their primary care teams, and South West CCAC case managers and the broader health community.<sup>17</sup> Support and education were provided for all members of the team specific to diabetes care, and three practice coaches assisted with team building, communication, as well as supporting the reporting process.

“CCAC case managers became an integral part of each team, attending in person at the team office, and taking part in education and improvement sessions.”<sup>18</sup> The overall findings concluded that by bringing together primary and community providers to create teams, there were improvements in communication, collaboration, and care planning, and there was a greater understanding of the CCAC. Patient satisfaction and quality of life also improved.<sup>19</sup>

### Recommendations

1. The OMA calls for CCACs to develop protocols to address urgent requests by physicians for patients who require home care in a timely manner.
2. The OMA calls for better mechanisms to communicate the results of pilot/demonstration projects in order to accelerate the pace of knowledge spread in the system.
3. The OMA supports the provision of palliative care in the home.

## Home Care: Summary Of OMA Recommendations

1. The OMA calls for Community Care Access Centres (CCACs) to develop protocols to address urgent requests by physicians for patients who require home care in a timely manner.
2. The OMA calls for better mechanisms to communicate the results of pilot/demonstration projects in order to accelerate the pace of knowledge spread in the system.
3. The OMA supports the provision of palliative care in the home.
4. The OMA recommends that Health Quality Ontario monitor Quality-Based Procedures (QBPs) for impact on both cost and quality of care as part of its annual quality report (The Quality Monitor).
5. The OMA encourages physicians to consider home care as part of their care planning and to make patient referrals to CCAC where appropriate.
6. The OMA recommends the availability and eligibility of all home care resources be made publicly accessible to inform and help manage expectations of patients and physicians and to identify gaps in services.
7. The OMA recommends that regional and provincial wait times, specific to home care, be monitored and publicly available.
8. The OMA calls for a mechanism to facilitate the exchange of information between physicians and case managers.
9. The OMA recommends standardized training and certification for case managers in home care.
10. The OMA recommends further exploration of models linking a case manager to physicians' practices.
11. The OMA calls for connectivity support for electronic health records to facilitate communication between physicians and health providers and CCACs.
12. The OMA encourages physicians to use technological advances to facilitate access to care (e.g., digital pictures for referral to wound care experts and participation in the Ontario Telemedicine Network).
13. The OMA recommends expanding tele-medical solutions (i.e., teleconferences, phone consultation including telemedicine) to allow for greater options for physicians to support their patients receiving home care services and for appropriate funding to compensate for this work.
14. The OMA encourages physicians involved in the care of homebound patients to make home visits.
15. The OMA recommends the development of training in medical school and for practicing physicians to support the provision of home-based medical care.
16. The OMA encourages physicians to be aware of the variety of health care providers and roles they can play as it pertains to home care and patient needs.
17. The OMA recommends a health human resources strategy to attract and retain highly skilled providers to the home care setting.
18. The OMA recommends increased availability of education and skills training for family caregivers to allow them to better manage the responsibilities involved with taking care of loved ones in their homes.
19. The OMA recommends increased investments into respite care and day programs in the community to support individuals and their caregivers in the community.
20. The OMA recommends ongoing government investments and tax savings for caregivers to acknowledge the important contribution made to their family or friends who require care at home.
21. The OMA supports volunteer services and agencies to explore options to provide patients with community services to maintain independence while living at home.

### 3. The Cost Of Home Care

As the demand for home care continues to grow in Ontario, budget constraints persist. In 2013, health care made up 42% of provincial program spending, with 4.1% of that dedicated to home and community care.

The cost of home care spending is difficult to tally due to the combination of public and private funding. However, a report released by The Conference Board of Canada showed spending for public home support in Ontario was more than \$1.6 billion, and private home health spending (paid for out-of-pocket by patients or by private insurers) had reached more than \$9.8 million, while increasing steadily over the previous 10 years.<sup>20</sup>

Private home health spending occurs when a patient is not eligible for publicly funded home care, or to supplement the care they do receive. This is permitted under the Canada Health Act. The Act makes a distinction between *insured health services* (i.e., those that have been deemed *medically necessary*) and *extended health care services*, which refers to home care and community care services. This distinction allows for a fee to be charged for some services based on an individual's circumstances. At present, home care services are provided to "supplement the care and support provided by family, friends, and community members or volunteers."<sup>21</sup>

As part of Ontario's Health System Funding Reform (HSFR), the Ministry of Health and Long-Term Care has been changing the way it funds health system providers, including hospitals, CCACs, long-term care facilities and others. HSFR includes two funding models that apply to CCACs: the Health-Based Allocation Model (HBAM) and Quality-Based Procedures (QBPs). The development of QBPs for the community will address the functional needs of patients as it applies to home care service utilization.

(Note: a summary of the origins of Quality-Based Procedures, and QBP experiences in other jurisdictions, appears on pages 14-17 of this issue.)

### Recommendation

4. The OMA recommends that Health Quality Ontario monitor QBPs for impact on both cost and quality of care as part of its annual quality report (The Quality Monitor).

### 4. Accessing Home Care In Ontario

Publicly funded home care is accessed through local Community Care Access Centres. The request for home care can be initiated by patients, caregivers (i.e., family), a referral by a physician (or other health care provider), or through hospital (following an admission or visit to the emergency department). A case manager/care co-ordinator employed by the CCAC will determine patient eligibility using a standardized assessment tool, the Resident Assessment Instrument for Home Care (RAI-HC), which "serves to guide CCAC case managers in the allocation of home services/funding and serves as the basis for standardized data to inform evidence-based care."<sup>22</sup> Once an assessment takes place, the case manager makes arrangements for supports and services to commence in a person's home.

While the CCACs are responsible for the assessment of patients' home care needs, service provider organizations (SPOs) are contracted by CCACs to deliver care. SPOs are accountable to the CCACs and are required to meet standards identified through a performance monitoring process. SPOs can provide an array of services, and in some cases specialize in an area such as nursing care. SPOs are represented in large part by the Ontario Home Care Association, which is a voluntary member association.

### The Physician Perspective

For most Ontarians, their first point of contact in the health care system is with their family physician, thus physicians have a role in identifying changes that might result in a discussion about or referral to home care.

Since the point of access for home care services can vary, physicians are often unaware of the home care services their patients are receiving. Once a physician refers a patient to home

care, there is often no followup from the CCAC. Physicians often depend on their patients to inform them of the care they are receiving in their home. In other instances, physicians report receiving a patient form by fax or mail with information that is not relevant, and the form provided by CCAC often varies from one LHIN to the next. For physicians who use electronic health records, receiving paper-based information is inefficient.

### Inequalities Of Home Care

When an individual requires home care services to function independently at home, to manage a chronic illness, or if supports are needed following a hospital stay, care needs to be provided promptly as delays can lead to additional health issues and adverse reactions. However, where you live can have a significant impact on the availability of home care services.

The 2012 Annual Report of the Office of the Auditor General (AG) of Ontario reports that "11 of the 14 CCACs have a wait list for various home care services,"<sup>23</sup> while the remaining three reported "virtually no wait lists at all."<sup>24</sup> The report suggests this may be due to an "inequitable distribution of resources among the 14 CCACs."<sup>25</sup> The AG report also found that "due to funding restraints, one of the three CCACs we visited had prioritized its services so that only those individuals assessed as high-risk or above would be eligible for personal support services...Clients assessed as moderate-risk were not deemed eligible...as a cost containment measure to achieve a balanced budget."<sup>26</sup>

Meanwhile, patients in other parts of the province and assessed at moderate risk were provided with personal support services. The data show that eligibility tends to depend on what care is available in the community through specific SPOs that provide care to patients through the CCAC, and also on the priority that is determined by the specific CCAC and/or the LHIN. This process does not always meet the needs of patients in the community and instead creates unequal access to care. The CCAC Quality Report 2010-2011 notes

additional inequalities specific to wait times. For a patient living in the community, the wait time to assessment is on average 16 days, and the wait time to the first home care visit is on average 37 days. In comparison, for patients in hospital, the wait time for assessment is five days, and wait time to the first visit is five days.<sup>27</sup>

### Recommendations

5. The OMA encourages physicians to consider home care as part of their care planning and to make patient referrals to CCAC where appropriate.
6. The OMA recommends the availability and eligibility of all home care resources be made publicly accessible to inform and help manage expectations of patients and physicians and to identify gaps in services.
7. The OMA recommends that regional and provincial wait times, specific to home care, be monitored and publicly available.

## 5. Case Management In Home Care

Case management in home care is employed as a way to centralize the overall care of patients. Case management refers to the central point of co-ordination of care for patients intended to “maximize the client’s ability and autonomy through advocacy, communication, education, identification of and access to requisite resources, and service co-ordination.”<sup>28</sup> In home care, case management is typically led by the CCACs. Case managers/care co-ordinators are tasked with helping patients navigate the system and determine eligibility for home care services. Case managers are the first point of contact at the CCAC and, based on eligibility, the case manager develops a care plan for the individual and manages any changes to home care services over time.

The role of case manager can be filled by a variety of health providers. In Ontario, the experience and educational background of the case manager can differ based on the needs of the patient. Some Canadian universities provide training for a certificate in

case management, which can be completed online in one year. The training is not mandatory, which is concerning for physicians as they are unaware of the experience and expertise of case managers. Standardizing training and certification for case managers would help ease these concerns. It would also make it easier for physicians and patients to know the differences among case managers to help determine the best fit for a patient’s needs.

### Evidence

Support for case managers seems to be growing internationally. The use of case managers in Europe demonstrated their effectiveness. A randomized trial in Italy studied how integrated social and medical care would impact frail elderly living in the community, with the goal of identifying a cost-effective approach to reduce admission to institutions and functional decline of patients.<sup>29</sup> One group of 100 patients received primary and community care through the conventional method, while an additional 100 patients received case management and care planning by the community geriatric evaluation unit and general practitioners. Two case managers performed an initial assessment and followed up every two months. They designed care plans and worked to integrate care by co-ordinating all available agencies in the care provided to the patient. The care team was composed of case managers, a geriatrician, a social worker, nurses and general practitioners, who were able to provide integrated care to patients because of the organizing case manager. At the end of the trial, it was determined that the group working with the case managers entered hospitals or nursing homes later and less often compared to the group with the conventional delivery of services. There was less physical and cognitive decline, and the total costs to the health care system declined.<sup>30</sup>

However, the success of case management depends a great deal on implementation. The Washington University School of Medicine (as part of the Medicare Co-ordinated Care Demonstration) found that the notion

of including a case manager in the care of a patient did not guarantee cost efficiencies and successful integrated care.<sup>31</sup> In fact, costs grew 12% in the initial phase of the study in 2002, and hospitalizations were not reduced. It took a major program redesign before improvements were achieved. The program was redesigned to combine in-person visits and phone calls to patients compared to the initial program, which involved case managers contacting patients solely by phone from a remote location. The redesign involving face-to-face meetings with patients resulted in decreased hospitalizations and Medicare costs.

Case management is often seen as a central place to co-ordinate the overall care of patients when looking to create integrated care. However, there is emerging research that disputes the efficacy of case management. A study by Huntley, et al,<sup>32</sup> raises some questions surrounding case management and its impact on unplanned hospitalizations among older people. The study looked at 11 trials of case management and found that there was no significant reduction in hospital readmissions. However, the study points out that there is limited data suggesting that related lengths of stay in hospital and emergency department visits are reduced.<sup>33</sup> The study also demonstrates that patients and their families report better experiences with their overall care, which is attributed to the case management they received.<sup>34</sup>

The role of case management in preventive care could have a positive impact on seniors who choose to age at home. In 1996, a preventive care approach was launched in Denmark for individuals over the age of 75, to have at least two preventive care visits annually by a case manager who was a nurse, occupational therapist, physiotherapist, or social worker. The case manager, employed by the municipality, visited the patient to assess his or her individual needs and assist with planning for independent living.<sup>35</sup> The case manager may also refer to a physician or other health care professionals when appropriate. These assessments set into motion the provision for publicly

funded home supports before a patient is in crisis and requires more advanced health care services.

### The Physician Perspective

Physicians and patients are unaware of the experience and training of case managers and the extent of the role and responsibility they play as patients receive home care. Physicians report little to no connection with case managers and, in some cases, speaking with the nurse providing the care would be more beneficial. Information gathered during consultations with physicians reveal that in some areas, case managers from CCAC have been designated to co-ordinate with medical offices. This face-to-face working arrangement is perceived as valuable by participating physicians.

### Recommendations

8. The OMA calls for a mechanism to facilitate the exchange of information between physicians and case managers.
9. The OMA recommends standardized training and certification for case managers in home care.
10. The OMA recommends further exploration of models linking a case manager to physicians' practices.

## 6. The Role Of Technology And Home Care

Poor communication can compromise patient safety. In a recent study, The Canadian Patient Safety Institute identified "communication failures, such as reliance on voice mail,"<sup>36</sup> as well as lack of standardized methods to share pertinent information, directly related to patient care.

There are opportunities to improve communication using technology. Home care nurses in British Columbia and Alberta are facilitating the referral process for patients requiring wound care interventions. By using a program called Picalere, nurses visited patients in their home to complete full assessments supported by digital pictures of the patient's wound, which were sent for an instant referral to the wound care technician.<sup>37</sup> This allowed the wound care specialist to gain remote access

to the patient, create an individualized care plan, and prioritize patient care based on urgency of need.

The Ontario Telemedicine Network (OTN) allows patients in northern and rural areas to have improved access to medical care through technology-enabled distance consultations. Patients get access to specialist and sub-specialist services without having to travel long distances to access care.

### Recommendations

11. The OMA calls for connectivity support for electronic health records to facilitate communication between physicians and health providers and CCACs.
12. The OMA encourages physicians to use technological advances to facilitate access to care (e.g., digital pictures for referral to wound care experts and participation in OTN).
13. The OMA recommends expanding tele-medical solutions (i.e., teleconferences, phone consultation including telemedicine) to allow for greater options for physicians to support their patients receiving home care services and for appropriate funding to compensate for this work.

## 7. Physicians As Part Of The Home Care Team

To meet the growing demands and expectations for home care, a health human resources plan is required. There are a variety of health professionals, including physicians, who play a significant role in the delivery of home care.

Physician home visits are recognized as an important element of home care. Historically, family physicians have provided home visits to patients, typically for their frail elderly patients who have mobility issues. The Ministry of Health and Long-Term Care has included home visits as a key strategy in its Ontario's Action Plan for Health Care.<sup>38</sup> Additionally, as part of the 2012 Physician Services Agreement, the Ministry agreed to invest \$10 million in house calls by physicians in an effort to address the needs of housebound and frail elderly patients. Implementation for this initiative is ongoing.

### The Physician Perspective

Making house calls feasible and attractive to physicians has raised much discussion. In addition to practice-specific concerns, there are remuneration issues. For those in health teams, including Family Health Teams, bonus incentives have been introduced based on a flat rate of house calls physicians make, but uptake remains low. Further discussion is needed to find ways to ensure fair compensation for this service.

Some physicians are concerned that medical schools do not sufficiently expose physicians to the skills required to care for people in their homes. Providing educational support to physicians is necessary to build their confidence and skills to allow them to be more involved in their patients' care.

Physicians acknowledge a need to become better integrated with home care to improve the transitions associated with patient care.

### Evidence

A program called Integrating Physician Services in the Home (IPSITH) was introduced in London, Ontario, in 2000-2002 to explore the impacts of integrating family practice and home care for acutely ill patients. The program compared the outcomes of the IPSITH group, which included a team of health care providers and the patient's family physician, to the *usual care*, which included using a case manager from the CCAC to evaluate a patient and assist in co-ordinating care.

Overall, the IPSITH program resulted in fewer visits to the emergency room.<sup>39</sup> While there were cost savings resulting from decreased patient visits to the emergency room, there were additional costs for physician house call fees and the nurse practitioner's salary.

The response to IPSITH was positive. Patients, caregivers, family physicians and nurses were all more satisfied in the IPSITH group compared to the non-IPSITH group.<sup>40</sup> This program demonstrated that family physicians can be successfully inte-

grated into acute home care when appropriately supported by a team.

Given the range of providers and varying models of care across Ontario, it can be difficult to co-ordinate patient care as they transition through the health care system. The Mississauga Halton Local Health Integration Network (MH LHIN) adopted the Home First strategy, which was introduced in an effort to reduce Alternate Level of Care (ALC) and achieve better outcomes for seniors through inter-organizational collaboration. The name of the program was the first step in adopting a cultural change by instilling the idea that "home is best" for patients. By aligning the leadership at hospitals and the LHIN in adopting the concept that "home is best," the next step was to convince health providers, families and patients.

Once there was sufficient buy-in, investments were made in new processes and strategies that recognized the benefits of aging at home in order to increase appropriate and adequate supports in the community.<sup>41</sup> By encouraging teams from Trillium Health Centre and Mississauga Halton Community Care Access Centre (MH CCAC) to work as one team and to focus on a patient-centred approach as they transition from hospital to the community, a new path of care was implemented. Success with this program has been attributed to adequate education, coaching and mentoring of physicians and other health care providers. The Home First approach has been expanded to other hospitals in the MH LHIN and other Ontario hospitals.

Another approach to help manage patient access is Health Links. Health Links are intended to support access to quality care for patients with complex conditions. As of October 2014, there were 56 community Health Links that have identified in their proposals patients with complex conditions specific to their geographical location. The goal is to increase system efficiency as these patients access and move through the health care system. Implementation of Health Links is continuing.

### Recommendations

14. The OMA encourages physicians involved in the care of homebound patients to make home visits.
15. The OMA recommends the development of training in medical school and for practicing physicians to support the provision of home-based medical care.

## 8. Allied Health Providers And Home Care

This section will explore a number of models of home care. It is not intended to endorse any particular model, but rather to demonstrate that a variety of approaches have been taken to meet local needs.

Well known for their role in providing home care, nurses are recognized “as important members of the health care team, fulfil many responsibilities including the role of case management, and direct service delivery offering nursing care.”<sup>42</sup> With the growing aging population and the shifting focus to home care, the Canadian Nurses Association predicts that two-thirds of nurses in Canada will be working in the community in 2020 compared to 30% in 2006. Ontario can expect to experience a similar pattern.<sup>43</sup>

The Ontario government has provided funding to CCACs for rapid response nurses (RRNs), who have been tasked with providing care to complex patients, in consultation with CCAC case managers in hospitals. The CCACs have hired 126 RRNs across Ontario to provide care to patients in their home within 24 hours following hospital discharge. RRNs review medication with patients and ensure that a followup visit with a family physician takes place within seven days. Early observations reveal a decrease in the readmission rate to hospital since the implementation of RRNs.<sup>44</sup>

Since nearly two-thirds of post-discharge adverse events can be attributed to medications, researchers reasoned that it makes sense to employ the expertise of a pharmacist. A study in *The Consultant Pharmacist* explored using a pharmacist to reduce readmissions to hospital within 30 days of discharge.<sup>45</sup> During this trial,

a pharmacist visited the patient in their home to review their medication following a hospital stay. During the visit, the pharmacist provided a comprehensive review of potential medication interactions and worked to optimize the patient’s medication regimen. In addition, the pharmacist assessed risks for patients in the home, including falls, mental health, nutrition and caregiver needs. This is in effect a case management type role where the pharmacist makes necessary connections between patients and nurses, social workers, and community resources, based on the pharmacist’s observations in the patient’s home. The pharmacist intervention during the transition from hospital to home resulted in a 30% reduction in readmission rates.<sup>46</sup>

Personal support workers (PSWs) “provide approximately 70% of home care services (i.e., support for the activities of daily living).”<sup>47</sup> PSWs are unregulated health professionals, however, in June 2012, the Ontario government launched a voluntary registry to “recognize their work and help to better meet the needs of the people for whom they care.”<sup>48</sup> PSWs are “most often tasked with bathing, house cleaning, meal preparation, laundry, baking, and medication reminders.”<sup>49</sup> They earn between \$11.50-\$18.36 per hour and are often casual or part-time workers who have an impact upon continuity and stability in this provider group.

In 2008, physician assistants (PAs) were introduced into the Ontario health care system and are working across the health care spectrum. Working under the supervision of physicians, PAs work in family practices, hospital emergency rooms and specialty practices. Physicians support expanding the Physician Assistant Program to allow for a larger reach for home care visits to homebound patients. A report published in 2013 evaluated the impact of a physician assistant home visit program in New York State and found that the 30-day readmission rate was reduced by 25%.<sup>50</sup> The Physician Assistant Program was created to provide house calls to patients recover-

ing from cardiovascular surgery. The study found that using the same highly trained PAs for both perioperative and intraoperative care, as well as for the followup visits, was integral to the success of the program.

In Toronto, paramedics are addressing the challenges of isolated and frail individuals. Introduced in 2006 as a pilot project, Community Referrals by Emergency Medical Services (CREMS) aims to address repeat calls to 911 by residents whose health condition has reached a crisis point. The individuals targeted by this program have difficulty connecting with appropriate resources, and in many cases are living with chronic disease that is not monitored or managed by a family physician. Following a call to 911, the attending paramedic, with the patient’s consent, provides a home visit to assess and provide immediate assistance, but then builds on that visit and refers the patient to the local CCAC for additional home supports and followup care, which includes finding a family physician for the patient. The program has been expanded since its inception, and calls (among the identified population) made to Toronto EMS have dropped significantly. There has also been a decrease in hospital emergency department visits.<sup>51</sup>

A similar program has been in place in rural Nova Scotia since 2001, where the Community Paramedicine program was introduced to fill the gaps in primary care for residents in the geographically isolated community of Long and Brier Islands. Paramedics with specialized training work in collaboration with the home care agencies, nurse practitioners and family physicians in an effort to provide patients with access to primary care.

### Recommendations

16. The OMA encourages physicians to be aware of the variety of health care providers and roles they can play as it pertains to home care and patient needs.
17. The OMA recommends a health human resources strategy to attract and retain highly skilled providers to the home care setting.

## 9. Unpaid Caregivers (Family And Friends)

When patients remain in their homes with home care, family and friends provide a tremendous amount of support, from transportation to personal care. The Health Council of Canada reports that family caregivers provide about 70%-75% of care.<sup>52</sup> Caregiving is stressful and time-consuming, and research demonstrates that those caring for “someone with severe cognitive impairment are at elevated risk of experiencing caregiver stress or burden.”<sup>53</sup> Both provincial and federal governments have recognized the important role of caregivers, namely through tax-reduction strategies, and in April 2014, the Ontario government passed Bill 21, The Employment Standards Amendment Act (Leaves to Help Families), which allows caregivers to provide support to family members without fear of losing their jobs. However, further strategies are needed to support caregivers.

### The Physician Perspective

Physicians are well aware of the burden of care that is placed on family caregivers. Physicians often witness the deterioration of the caregiver, who is often also their patient. Without appropriate support, caregivers may not be able to continue their important role as primary caregiver. However, physicians also understand that sometimes the home environment contributes to the patient’s decline and that the formal system must be activated.

### Evidence

A recent study examined the safety of home care for patients and used adverse reactions to determine risk. The report showed that the most common adverse reactions were infections, followed by falls and medication-related incidents. The study acknowledged the “impressive contributions of all those who are engaged in providing quality care to hundreds of thousands of Canadians,”<sup>54</sup> however, it strived to identify the areas where improvements could be made to prevent adverse events. One of these risks was identified as “the ability of clients and their families to act as indepen-

dent decision-makers.”<sup>55</sup> Essentially, patients and their caregivers often do not reveal the full breadth of their needs in an effort to maintain their independence while living at home. By accepting less help than they need, they are in effect putting themselves at risk for their condition to deteriorate.

Almost 750,000 Canadians over the age of 65 are living with dementia, and that number is expected to double by 2031.<sup>56</sup> “Half of those with dementia live at home,”<sup>57</sup> which creates a physical and mental drain on caregivers. In addition, “many family members reported feeling unheard when they expressed concerns or an inability to continue providing care.”<sup>58</sup> Respite care is not available as often as it is needed, and most patients, even those with complex needs, only receive two to three hours of home care a day. Community day programs are lacking, which places the burden of caregiving on family members.

In 2011, the Ontario government introduced the Behavioural Supports Ontario (BSO) project, which offers specialized training to frontline staff to provide support for patients who exhibit responsive behaviours related to dementia, mental health, and neurological conditions, and their families who are living at home and in long-term care facilities. At the end of 2012, the Ontario government announced an additional \$40 million to train personal support workers in the BSO project to better support this patient population. The BSO project aims to provide appropriate supports and interventions to families of patients living at home. An evaluation of the project is ongoing, and measures are needed to ensure that the BSO is providing appropriate support not only to long-term care homes, but to formal and informal caregivers of home care patients.

With a growing aging population and a focus on aging at home, it is clear that investments are needed to improve the availability of education and training for caregivers, specific to the patient’s condition.<sup>59</sup> A study by Graff, et al, followed patients’ progress after 10 sessions with an occupational therapist who also provided training for caregivers to deal with patient con-

ditions. Not only were there improvements in the condition of patients, but the benefit was sustained because of the intervention to train caregivers.<sup>60</sup> Caregivers also demonstrated more confidence in dealing with day-to-day activities, and study participants expressed diminished burden as caregivers. The research concluded that when caregivers can manage their stress they become better caregivers.

### Recommendations

18. The OMA recommends increased availability of education and skills training for family caregivers to allow them to better manage the responsibilities involved with taking care of loved ones in their homes.
19. The OMA recommends increased investments into respite care and day programs in the community to support individuals and their caregivers in the community.
20. The OMA recommends ongoing government investments and tax savings for caregivers to acknowledge the important contribution made to their family or friends who require care at home.

### 10. Volunteers

Volunteers in the community are an untapped resource in providing services to help enhance the life of patients at home. With specialized training and guidance, dedicated volunteers can visit with patients to engage them in conversation, help them with meals, and assist with supporting patients' mobility. Hospitals already utilize volunteers to do this type of engagement, and a similar volunteer role could be extended to patients in the home.

### The Physician Perspective

Physicians see an opportunity for volunteers in the community to play a larger role caring for patients in their homes.

### Recommendation

21. The OMA supports volunteer services and agencies to explore options to provide patients with community services to maintain independence while living at home.

### 11. Next Steps

This paper is intended to provide an understanding of the home care landscape in Ontario, highlight a variety of models of care, present the unique perspective of physicians and their experience with home care, and includes recommendations to support physicians and their patients as they access home care services.

The preceding discussion highlights the need to better integrate home care services into the broader health care system. Resources are being shifted from other areas of the health care system, and there is a need for additional investment in the future to ensure a robust and sustainable home care system that is in line with patients' needs and preferences.

The OMA recognizes that the recommendations in this paper are broad-reaching and will require action at various levels in the system. We will work with our partners to explore and implement solutions to enable more patients to receive appropriate and effective care at home. ■

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