

Ontario Home Care Association

**Submission to Dr. Samir Sinha
Senior Care Strategy for Ontario**

July 2012



At a Glance....

Ontario's *Seniors Care Strategy* is intended to address health system capacity ensuring the right service by the right provider at the right time and in the right location. The Ontario Home Care Association (OHCA) believes that central to this strategy is the reframing of society's assumptions regarding aging. OHCA recommends that the *Seniors Care Strategy* include the following elements:

- Support for seniors to be as well as they can be
 - Normalize healthy aging at home such that care decisions are always made considering the context of maximizing independence at home
 - In addition to post acute care, apply the findings from the *Valuing Home and Community Care Project (2010)*¹ to proactively support seniors with some impairments related to aging (moderate MAPLe² scores).
 - Increase the array of programs and services to support activities of daily living for seniors and ensure easy access for seniors and their families.
 - Implement chronic disease prevention and management strategies targeted specifically at seniors, for example, actively addressing the rehabilitation needs of the elderly
 - Develop and apply research evidence that is relevant to the senior population recognizing the heterogeneity and complexity of this age group.

- A robust home care system
 - Improve home care entitlements (see Appendix 1) so that those with some impairments related to aging who are at increased risk of a acute event are not required to prematurely alter their living arrangements in order to relieve families and/or receive care and remain safe.
 - Invest in services to support the highly successful HOME First³ philosophy that prevents further destabilization of the senior subsequent to an acute care intervention
 - Ensure a range of integrated, client-centered, quality and appropriate health, mental health, and support services is available, responsive and accessible reasonably close to home so seniors can maintain their family and community connections.
 - Develop senior-specific expertise within the health care team.
 - Invest in technology to leverage and enhance the capacity of the home care system. For example:
 - Point of care documentation with system linkages to enable timely access by team members, including the client and family, to relevant care information
 - Remote monitoring to access experts for clinical consultation (i.e. wound management), to allow for virtual visits by members of the team

¹ Boston Consulting Group (2010) Valuing Home and Community Care Key findings and path forward. Retrieved from <http://www.homecareontario.ca/public/about/publications-HCC.cfm>

² The MAPLe (Method for Assigning Priority Levels) is a set of rules derived from the RAI-HC; it assigns clients to one of five levels (from low to very high) and provides information about their risk of adverse outcomes. Clients in the low category have no major functional, cognitive or environmental problems. They would not be at great risk of adverse outcomes and therefore would be unlikely to require admission to a LTCF. Clients in the very high category are at risk of adverse outcomes based on their greater problems in cognition, ADL function and/or behaviour.

³ HOME First is a program that helps older adults return home with the necessary post-hospital supports to safely continue healing when their acute care hospital treatment is complete. The program promotes better long-term health outcomes, with more than half of the Home First clients becoming well enough to remain in their home, with a reduced level of CCAC support. (From <http://www.centraalhinc.on.ca/page.aspx?id=14898>)

- On site devices and systems that trigger alerts thereby mitigating risks.
 - Encourage interdisciplinary collaboration across the health system continuum.
- Support for family caregivers
 - Adopt meaningful measures that would demonstrate the value placed on family contributions to keeping loved ones at home include additional respite hours, caregiver education, adult day programs, tax incentives including HST exemptions on privately purchased on home care, and job protected time away from work to provide care.
- Accommodation of the needs and preferences of seniors
 - Ensure Ontarians have easy access to decision support tools and clear information on services and care options so they can retain the right to live where and how they wish.
 - Flexible service provision in order to provide care that meets the needs and preferences of the client and family should be the priority.
 - Increase awareness and reporting of any form of mistreatment of the elderly including abuse.
 - Promote volunteerism so that Ontarians of all ages are aware of the importance of assisting seniors to remain at home.

Sound structure will support the implementation of the Seniors Care Strategy. The Local Health Integration Networks (LHINs) as regional health organizations work with local health providers and community members to determine the health service priorities of their respective regions. In addition to their responsibilities to plan, integrate and fund local health services, the LHINs need to broaden their scope. By working with all service providers in the community, including the non transfer payment providers, the LHINs will be better able to leverage their community resources in order to address the health needs of their population.

The Community Care Access Centres (CCACs) serve as the point of access for care in the community. The role of the CCAC case manager as a system navigator needs to be strengthened and positioned to complement the appropriate clinician as the clinical manager responsible to facilitate safe and appropriate care and care transitions.

Introduction

The demographic profile of Ontario is one of an aging society. The number of people aged 75 and over is projected to rise from 865,000 in 2010 to almost 2.2 million by 2036. The 90+ group will more than triple in size, from 79,000 to 291,000.⁴ Projections indicate that in twenty years, 10.6 per cent of the population will be over 75 years old.⁵

Seniors, as a group, are healthier and more active; and the seniors of the future are predicted to be amongst the healthiest in history. However, a consequence of aging is that the likelihood of developing chronic conditions and long term illness increases and can compromise the prospect of independence.

Ontario has already begun to plan for the shifting demographic and associated health care needs. Recognizing the different drivers for care, the Ministry of Health & Long-Term Care (MOHLTC) has

⁴ Ministry of Finance. (2010) <http://www.fin.gov.on.ca/en/economy/demographics/projections/>

⁵ Ibid

undertaken initiatives that will transform the health system from one that is reactive and focused on cure to one that is proactive and driven to support individuals to live independently and to self-manage their conditions as well as possible. To advance this agenda and ensure a coherent and coordinated approach to the care of seniors, Minister of Health & Long-Term Care Deb Matthews commissioned the development of a *Seniors Care Strategy* for Ontario under the leadership of Dr. Samir Sinha. In the fall of 2012, Dr. Sinha will provide recommendations to the Minister on how the health system can support more seniors to live independently at home and in their community. This paper serves to summarize the perspective and recommendations of the Ontario Home Care Association (OHCA).

Background

Most, if not all people, wish to remain independent during their older years. **Successful aging requires a holistic approach** – avoiding disease and disability; maintaining cognitive ability; and engaging with life.⁶ One of the most significant and least desirable outcomes for a community dwelling senior is to be prematurely institutionalized⁷ because of the lack of home and community care based health and social support options.

Home Care

Home care is defined as an integrated “array of services, provided in the home and community setting, that encompass health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration and support for the family caregiver”^{8 9}.

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

There is a synergistic relationship between home care and community services which is further supported and described as ‘the provision of health care, community and social support programs that enable individuals to receive care at home and/or live as independently as possible in the community’¹⁰.

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

An estimated 20 million visits/hours annually are purchased privately in Ontario.
OHCA 2010

⁶ Rowe, J. W., & Kahn, R. L. *Successful aging*. Gerontologist, 37, 433–440, 1997

⁷ 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) are outside of the control of the individual

⁸ Canadian Home Care Association

⁹ For more about home care in Ontario, see Appendix 2.

¹⁰Report to the Annual Premiers’ Conference, “Strengthening home and community care across Canada: A collaborative strategy, August 2003

Seniors at Risk

Seniors with chronic conditions and disabling physical limitations requiring help with everyday activities such as housework and meal preparation are at imminent risk of institutionalization due to falls and other adverse events.¹¹

Elderly, single, cognitively impaired women with physical dependence and depression are also identifiable as high-risk for institutionalization.¹²

Dementia is one of the major risk factors for loss of community-dwelling status. Several randomized trials of mental health interventions with medical patients over the age of 75 showed that those in the intervention group had improved physical function, few readmissions to hospital and nursing homes.¹³ Supporting individuals with early stages of dementia is compassionate and potentially effective to maintaining independence and dignity for individuals.

In 2011, the publicly funded home care service provided 29.2 million hours of service to 619,952 Ontarians.

Retrieved from MOHLTC Health Data Branch

Growing numbers of community-dwelling seniors are ‘at risk’ for loss of independence because they need more help than is currently available in the health care system to age at home. Investment in supportive care to enable optimum functioning for individuals at the ‘fringe’ of admission to a care facility can help to tip the balance of care to the community thereby avoiding the often rapid dependence on others which arises out of care in

other settings. Ontario’s provincial home care program is vital to supporting the publicly insured system by enabling early discharge of patients from hospitals and providing an alternative to long-term care homes. **For the overwhelming majority who prefer to remain in their community, home care is both cost effective and care effective.**¹⁴

Ontario’s *Seniors Care Strategy* is intended to address health system capacity ensuring the right service by the right provider at the right time and in the right location. For an estimated 93% of seniors, this means that access to health care at home must be improved. Too many Ontarians continue to seek primary health care in hospital emergency departments and too many hospital beds are used to care for non-acutely ill people who could be at home with supports. The system must change to help these people get more appropriate care through a well resourced and well-coordinated home care system that is integrated with the broader health sector.

OHCA recommends that the *Seniors Care Strategy* include:

- Support for seniors to be as well as they can be
 - Normalize healthy aging at home such that care decisions are always considering the context of maximizing independence at home

¹¹ Wilkins, Park, “Chronic Conditions, physical limitations and dependency among seniors living in the community” Statistics Canada, 1996 and Fletcher, PC and Hirdes, JP, “Risk Factors for Falling Among Community-Based Seniors Using Home Care Services”, *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences* (57:M504-M510) 2002

The Journals of Gerontology Series A: Biological Sciences and Medical Sciences 57:M504-M510, 2002

¹² J Woo, SC Ho. An Estimate of Long Term Care needs and identification of risk factors for institutionalization, *Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, Vol 55, Issue 2 M64-M69, 2000

¹³ Burns, A, Denning, T and Baldwin, R *BMJ* Volume 332, 31 March 2001 (4a)

¹⁴ VanderBent, S., Kuchta, B. (2010) *Valuing Home and Community Care*, p3

- In addition to post acute care, apply the findings from the *Valuing Home and Community Care Project* (2010) to proactively support seniors with some impairments related to aging (moderate MAPLe scores).
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 - Implement chronic disease prevention and management strategies targeted specifically at seniors, for example, actively addressing the rehabilitation needs of the elderly
 - Develop and apply research evidence that is relevant to the senior population recognizing the heterogeneity and complexity of this age group.
- A robust home care system
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- Adopt meaningful measures that would demonstrate the value placed on family contributions to keeping loved ones at home include additional respite hours, caregiver education, adult day programs, tax incentives including HST exemptions on privately purchased on home care, and job protected time away from work to provide care.
- Accommodation of the needs and preferences of seniors
- Ensure Ontarians have easy access to decision support tools and clear information on services and care options so they can retain the right to live where and how they wish.
 - Flexible service provision in order to provide care that meets the needs and preferences of the client and family should be the priority.
 - Increase awareness and reporting of any form of mistreatment of the elderly including abuse.
 - Promote volunteerism so that Ontarians of all ages are aware of the importance of assisting seniors to remain at home.

These key elements of the *Seniors Care Strategy* will address the needs of seniors today and serve to direct the shift of the health system to one that is focused on care at home as the goal underpinning

care. **Success will be measured by the numbers of seniors remaining independent at home, the rate of use of other sectors of the health system and by the shift in clinical practice to first and foremost considering how best to support care at home.**¹⁵

Elements of the Seniors Care Strategy

➤ HEALTH PROMOTION AND INJURY PREVENTION

Health problems can prevent full participation in community life. While seniors today are typically healthier and more independent longer in life, the demographic shift is driving the need in Ontario to broaden the approach to health care and leverage resources to support seniors to remain independent at home for as long as possible. Chronic conditions are more prevalent among the elderly and the proportion of seniors with a disability or handicap also rises with age. The number of chronic conditions has been found to be the strongest determinant of the frequency with which seniors consult physicians and use medications. As the number of elderly people in the population grows, so will the prevalence of age-related chronic conditions that may jeopardize an individual's ability to live independently in the community."¹⁶

The ability to remain at home is in large part determined by an individual's ability to manage their living circumstances, whether it is a house in a rural or urban setting, an apartment or assisted living environment. Social isolation and escalating fears about safety risks can prompt the family and/or the health care team to recommend an institutional option. The work of maintaining a home, cleaning, snow shoveling, and home repairs can become too difficult for seniors and their families. Research has shown that the balance of care can be tipped to remaining at home when supports that address isolation and simple assistance with home maintenance are provided.¹⁷

Another important group benefiting from **preventative home care** is the growing numbers of community-dwelling seniors are 'at risk' for loss of independence. These are the people, who may or may not be compromised by chronic disease but who are at the 'fringe' of stability. They need a little more support than offered within the community system but not the full scope of services offered in the facility. It is at this point where enhanced and focused services delivered in the home make a major difference in their quality of life and in the use of health system resources. A randomized controlled trial has presented clear evidence that providing seniors with proactive nursing health promotion compared to providing professional services on demand, results in enhanced quality of life related to early identification and management of risks for adverse events (i.e. falls, polypharmacy, depression, caregiver stress) at no additional expense.¹⁸ The previously mentioned Valuing Home & Community Care Project also provided solid evidence as to the cost and care effectiveness of proactive home care for those with moderate impairments.

Seniors are particularly susceptible to the effects of drugs and incorrect complex medication regimes which may result in adverse events such as institutionalization or hospitalization.¹⁹ Programs such as Ontario's MedsChek and the integration of the pharmacist onto the primary care team lend themselves

¹⁵ VanderBent, S., McAlister, M. Can this care be provided at Home? Unpublished

¹⁶ Statistics Canada. 2006. *Seniors and Home Care*. Stats Can Catalogue no. 82-003-XIE. Ottawa. www.statscan.ca

¹⁷ Challis, D and Hughes, J. (2002) *Frail old people at the margins of care: some recent research findings* British Journal of Psychiatry 180 126-130

¹⁸ M. Markle-Reid, et al. *Frail Elderly Home Care Clients: The Costs and Effects of Adding Nursing Health Promotion to Personal Support Services*. Ottawa, Ontario: Canadian Health Services Research Foundation, 2003. Print.

¹⁹ Hogan, D, Maxwell, CJ, Fung, TS, Ebly, EM "Prevalence and potential consequences of benzodiazepine use in senior citizens: Results for the Canadian Study of Health and Aging" *Canadian Journal of Clinical Pharmacology*, Vol 10 No 2 Summer 2003

to proactive assessments and interventions of those with characteristic presentations, such as confusion and falls.

Recent Canadian and international research suggests that **community-based services that are integrated and co-ordinated across the health care system can be a cost-effective way to maintain seniors' independence and that it can prevent premature admissions** to hospitals and long-term care facilities.²⁰ **The availability of home care services can facilitate early discharge from an institution** effectively addressing the number of patients waiting in hospitals that do not require intensive / acute care – a challenge in Ontario's health system.

Ontarians want to receive care in their homes, and if given a choice would prefer early discharge from hospital followed by provision of home care. Enhanced and focused services delivered in the home can make a major difference in the quality of life for both the senior and their families.²¹ **Acknowledging home as the care destination should trigger care decisions that consider the context of maximizing independence at home.**

➤ ACCESS TO QUALITY HOME CARE SERVICES

Having chronic conditions also increases the likelihood of being hospitalized and receiving home care.²² Improved outcomes for clients/patients have been realized through the integration of home care in emergency departments, primary care and palliative care.²³

People want to be at home and it is generally the best place for people of all ages to recuperate from an illness, manage a long term care condition or to live out their final days. However a health crisis can often precipitate decisions on where care will be most appropriate for a senior and result in a premature change in care setting. **Initiatives, such as Home First, have demonstrated that a well resourced, flexible and anticipatory home care system sustains individuals within the community longer than previously imagined and provides the best circumstances to determine a long term care plan.**

Avoiding premature institutionalization of the elderly ensures that the institutional bed is reserved for those with the greatest need and saves precious health system resources. Home and community care is a cost-effective infrastructure investment both in the short and long term, particularly when it is focused locally on specific populations at risk, such as frail and vulnerable seniors with loving families who want to care for them at home. Even small amounts of home care will make a difference in people's lives, allowing them to remain independent of the full scope of services offered in a facility. To achieve the goals of the health system, transformative changes must be made to realize the role that a strong and robust home care service plays in maintaining balance in the fragile system of health care.

It is **imperative that providers coordinate care and that clients/patients are supported as key members of the integrated team.** Many seniors are particularly vulnerable to the lack of coordination and communication between different sectors in the health care system.²⁴ Recent

²⁰ Béland F. et al (2006) *A system of integrated care for older persons with disabilities in Canada: Results from a randomized controlled trial* | *Gerontol A Biol Sci Med Sci*. 2006 Apr; 61(4):367-73.

²¹ Challis, D and Hughes, J. (2002) p 126-130

²² Rotermann M. (2006) *Seniors' health care use*. Statistics Canada. 16(Suppl.): 33-45

²³ Canadian Home Care Association - High Impact Practices. Retrieved from <http://www.cdnhomecare.ca/content.php?doc=46>

²⁴ McWilliams, C.(1993)

hospitalization and poor transition planning following discharge from acute care is a known precursor of loss of independent living.²⁵ This occurs because appropriate supports (such as assessments and care plans) to enable a durable discharge are not planned and communicated to the next caregiver. An integrated and effective health system addresses the transition points of care and works to ensure safe and consistent bridging of services and/or sectors.²⁶

The Institute of Clinical Evaluative Sciences (ICES) has reported that if a nurse visits an individual within seven days of discharge from hospital the likelihood of readmission is reduced by 20-25%. The benefits to the health system, clinician time and the patient are obvious and compelling.

An efficient and effective home care system appropriately utilizes and integrates all members of the team to achieve value and to assist Ontarians who wish to receive care at home and remain independent. Providing the full array of home care services, including access to case management, family physicians, nursing, therapies, community pharmacists and personal support is essential to support good health outcomes. OHCA recognizes and values the important contribution that the interdisciplinary team makes to home and community care. Each interdisciplinary member has a unique body of knowledge and scope of practice which must be respected and leveraged in order to maximize their effectiveness for client care. The team based approach ensures that the outcomes realized are greater than the sum of the parts – in other words, value is realized.

➤ SUPPORT FOR FAMILY CAREGIVERS

Family caregiving is crucial to keep seniors at home and the important contributions of families must be recognized. While caregiving is a positive experience for many, family members can struggle to balance the competing demands of work, family and care for elders.

Families and caregivers that have gone beyond their physical and emotional ability to cope are more likely to consider institutionalization of a senior. This occurs because families are expected to bear the greatest burden of care for a senior loved one. The current **home care system depends heavily on family and friends to provide the majority of continuous care** and support in the community and this is unsustainable for many families.²⁷ Research has shown that family counseling and mental/emotional health support for caregivers can reduce the rate of institutionalization for some groups of seniors with Alzheimer's disease.²⁸ **Investment in planned respite that addresses the caregivers' needs** and acknowledges their importance to keeping our elders at home is critical to ensuring the sustainability of the caregiver role.

A clearly identifiable trigger point for imminent loss of independence occurs when families decide, with the support of the Community Care Access Centre or family physician, to activate the search for placement for the senior to a retirement or long term care facility.

²⁵ Hollander, M., Chappell, N. (2002)

²⁶ VanderBent, S. (2004) Key Quality Processes and Outcome Measures. The Ontario Home & Community Care Council.

²⁷ Naleppa, MJ. Families and the Institutionalized Elderly, *Journal of Gerontological Social Work*, Volume : 27 Issue : 1 / 2, 1994 (p.87)

²⁸ Mittelman MS, Ferris SH, Steinberg, G, Shulman, E, MacKell, JA, Ambinder A, and Cohen J "An Intervention that delays institutionalization of Alzheimer's disease patients: treatment of spouse-caregivers" *The Gerontologist*, Vol 33, Issue 6 730-740 1993

This activity is often initiated for individuals at the 'fringe' - those needing a little more support than offered within the community system and not really requiring the full scope of services offered in the facility. It is at this point where enhanced and focused services delivered in the home could make a major difference in the quality of life for both the senior and their families.

Families, as integral to care at home need to be effectively supported. Of immediate importance is safeguarding the health and wellbeing of family caregivers and increasing the flexibility and availability of respite care.

➤ ACCOMMODATION OF NEEDS AND PREFERENCES

Aging at home is what most people want and Ontario should continue to facilitate that choice. As the province increases its commitment to enabling seniors to optimize their well-being, care providers must adopt a greater commitment to client-centred care. Society will shift to an increasingly greater awareness of senior rights and senior-friendly policies and initiatives.

Respect for individuals regardless of where or how they choose to live is fundamental to effective care in the community. Home and community care providers respect the rights and choices inherent to clients within their own homes. Providers are acutely aware of the delicate balance between the need to create a safe working environment for home care staff and providing safe care for clients while respecting their individual rights within their own homes. Individual homes lack many of the safety specifications found in the institutional setting; and as a result clients may be more vulnerable to adverse events in their own home environment. Home care staff must be constantly vigilant and prepared to address the potential for injury in the home, such as from slips and falls on surfaces that may not be optimum for proper ambulation. **Modest home modifications facilitate access and safety.**

Home and community care organizations resource their staff to provide safe care. Staff are well informed and trained in safety procedures and have the ability to improvise in the home setting while applying approved safety principles for care. The front-line home and community care staff member, whether a paid or volunteer worker, is a special and unique individual who enjoys the variability and new challenges that exist within each home environment. In addition to organizational support, home and community care staff, who often work alone, must display personal attributes of maturity, self confidence, flexibility and creativity in applying policies in order to ensure their own and their client's safety.

Issues relating to distance and population density and connectedness to social support in urban settings must be addressed. Enhanced programming for those without family support through both formal care and volunteers are effective strategies to helping people remain at home.

Innovative technology is an enabler of improving the vital linkages with primary care and community based organizations. Active and passive remote monitoring has been shown to effectively complement the home care practitioner, enabling access to health care when the provider cannot be present in person.²⁹

²⁹ Canadian Home Care Association (2008) Integration through Information Communication Technology for Home Care in Canada Final Report

Conclusion

The landscape in Ontario is changing and health care policies need to keep pace. The shift in focus is from caring “for” seniors to caring “about” seniors. Healthcare delivery, albeit a significant component of senior friendly policies, is just one part of the solution. Nevertheless, the *Seniors Care Strategy* provides an important opportunity to continue the transformation of the health system concretizing the government’s goal “to make Ontario the healthiest place in North America to grow up and grow old”³⁰.

About the OHCA

The OHCA, *the voice of home care in Ontario*, is a membership association representing providers of quality home care services from across Ontario. OHCA members represent an estimated 25,000 staff collectively serving 300,000 Ontarians per year. OHCA works with families as integral partners in the delivery of home care services and as such estimates that 1.2 million Ontarians are impacted by members. OHCA is dedicated to promoting the growth and development of the home and community health care sector by helping to shape health care policy, supporting members to excel, and being a leading source of information on home and community care. OHCA members are accredited through Accreditation Canada, CARF, and/or registered with the International Standards Association (ISO).

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³⁰ MOHLTC 2012 Action Plan for Ontario

Appendix 1

Current entitlements are:

- **Nursing services** are provided based on assessed need up and to be no more than the lesser of the following amounts of nursing services:
 1. 28 visits from a registered nurse or a registered practical nurse in a seven-day period.
 2. The following number of hours of service in a seven-day period :
 - i. if services are provided by registered nurses, 43 hours of service,
 - ii. if services are provided by registered practical nurses, 53 hours of service, or
 - iii. if the services are provided by both registered nurses and registered practical nurses, 48 hours of service.

http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/cspm_sec_7/7-2.html

- There are no regulated service maximums for the other professional health services provided by the CCAC.

http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/cspm_sec_7/7-2.html

- **Personal Support/Homemaking services** are provided based on assessed need and to be no more than the following:
 1. 80 hours, in the first 30 days that follow the first day of service.
 2. 60 hours, in any subsequent 30-day period.

More than the maximum number of hours of homemaking and personal support services can be provided for a period of up to 30 days if the CCAC determines that there exists extraordinary circumstances that justify the provision of additional services.

http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/cspm_sec_7/7-3.html

Appendix 2

Home Care in Ontario

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

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

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

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

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

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