

Home Care in Ontario – Building on Successes for the Future

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The true meaning of health reform is embodied in the shift from facility-based care to home and community-based care. In Ontario, the transformation of the health care system to the home and community sector was significantly enhanced in 2004 when the first ministers agreed to the 10-year plan to strengthen health care.¹ The home care provisions affirmed the assertions of the time that home care was essential to the overall health system.

In Ontario, home care has emerged as a vital component of an integrated health system. The pressures to increase funding and shift policy toward home care, as outlined in 2003 by the Ontario Home Care Association (OHCA)² continue and are converging such that there is an urgent need to sustain the gains and commit to renewed efforts and strategies.

An aging population

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 291,000.³ Projections indicate that in twenty years, 10.6 per cent of the population will be over 75 years old.⁴ This shift is, in part, a testament to our success as a society. Seniors, as a group, are healthier and more active; and the seniors of the future are predicted to be amongst the healthiest in history. A consequence of advanced age can also be the likelihood of developing chronic conditions and long term illness that threaten 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 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.

Home care, as a relatively newer addition to the health care landscape, has an important role to play in helping the growing number of older people who are coping with the management of longer-term illnesses and health conditions. The critical need for a better system of care in the home will grow exponentially in the next 20 years.

Home Care

Home care is more than a basket of services. It is an integrated “array of services, provided in the home and community setting, that encompass health promotion and teaching, curative

¹ Commonly known as the 2004 Health Accord. For more information, <http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php>

² In 2003 the Ontario Home Care Association was known as the Ontario Home Health Care Providers' Association (OHHCPA). The original paper, [Core Basket of Services for a National Home Care Program](http://www.homecareontario.ca/public/about/publications-position-papers-archive.cfm), can be found at <http://www.homecareontario.ca/public/about/publications-position-papers-archive.cfm>

³ Ministry of Finance. (2010) <http://www.fin.gov.on.ca/en/economy/demographics/projections/>

⁴ Ibid

intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration and support for the family caregiver”⁵.

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’⁶.

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.

OHCA recognizes and values the important contribution that the members of the interdisciplinary team make to individuals living at home. Each interdisciplinary member has a unique body of knowledge and scope of practice or task which is essential to good care outcomes and also to the achievement of a high quality health system.⁷ These system outcomes include:

- ALC reductions – ensuring that time in the acute care setting is kept to a minimum and recovery to self care at home is expedited
- Emergency Department avoidance – providing proactive support to forestall a health related crisis and hospital admission; and being available 24/7 to respond to care needs as they arise in the community
- Palliative and end-of-life care – supporting pain and symptom management and providing caregiver support so that a person can have a peaceful death at home
- Children’s treatment – enabling children with health related risk (medical, developmental, social, or mental) to maximize their potential both at home and at school
- Chronic disease management – proactively assisting individuals so they can effectively self-manage at home, circumventing the need for hospitalization, and delaying loss of function and independence.

⁵ Canadian Home Care Association

⁶Report to the Annual Premiers’ Conference, “Strengthening home and community care across Canada: A collaborative strategy, August 2003

⁷ A number of papers describing the role and value of the various members of the home care team are available at www.homecareontario.ca/public/about/publications-home-care-team.cfm

Home Care delivers both health and social care

A person of any age who is medically challenged, or lives with a life-long illness, has both health care and social care needs. It is for this reason, that home and community care advocates believe that it is a very broad and diverse sector which must address the determinants of health such as the need to receive health care as well as assistance with other ordinary activities of daily living. Good care is predicated on supporting families and meeting both the health and social needs of the individual on a consistent and on-going basis.

The challenge is to ensure the appropriate integration of both social welfare and health care needs while acknowledging that there is a financial cost to broad service delivery. Compared to many other parts of Canada, Ontario is fortunate to have a home and community care system, which legislatively acknowledges both the social and home health care needs of individuals. Financially, there is no user fee imposed on those individuals who are deemed eligible for services through the publicly-funded home care system administered by the Community Care Access Centres. Additionally, the government has invested in health and social programs such as Aging at Home⁸ and Home First⁹ to assist the elderly with complex needs to remain independent at home for as long as possible.

Reforming the health system

Health care reform cannot take place in isolation of our existing health care infrastructure and practice. Hospitals are still large cost drivers in Ontario's health care system - a fact that cannot be ignored. However, system change is necessary and must be accelerated due to current financial imperatives. Technological advances that continue to drive acute care costs must be analyzed from a health and social utility perspective.

Transition points (community to ER; ER to community; hospital to community) must be seamless to improve and modify patterns of existing practice. It is within these transition points that leveraged change activities will achieve the greatest impact.

The success of health care reform which is embodied in the shift from facility to home and community based care is dependent on the support of families and loved ones. In a 24-hour day, only a small amount of care is given by paid staff. Health care reform will only continue if families are supported to maintain their natural and desired care-giving role. Without the financial acknowledgement of the fundamental reliance of the home and community care system on the dedication and presence of the family, institutionalization will be the only option for many individuals.

⁸ An investment of more than \$700 million over three years introduced in 2007. The purpose was to provide more community living options for seniors with a wider range of home care and community support services available to enable people to continue leading healthy and independent lives in their own homes. See. http://www.health.gov.on.ca/english/public/program/ltc/33_ontario_strategy.html...

⁹ A philosophical approach to managing acute care patients differently – avoiding deterioration in hospital or judging patients as 'unable to return home'. The focus is on making discharge home possible and avoiding discussion about LTC placement in hospital. CCAC and Community Support Services (CSS) are mobilized to enable discharge home. Retrieved from <http://www.ccac-ont.ca/Content.aspx?EnterpriseID=10&LanguageID=1&MenuID=144>

Health system transformation in Ontario is grounded in organizing care around the person and improving the health outcomes of individuals. New provincial initiatives are promising to strengthen both team and system integration so that Ontarians with health challenges receive seamless, coordinated health care from a collaborative interdisciplinary team (e.g. nurse, therapist, physician, personal support worker). In all health and social care settings, the team must be focussed on achieving the best health outcomes for the client, both clinical and experiential.

Achieving Quality

Providing quality health care to Ontarians is a fundamental principle on which the government of Ontario bases health care policy development. The *Excellent Care for All Act (ECFAA)* is intended to strengthen health care organizations' accountability for quality and to reinforce principles of organizing care around the individual.¹⁰ The OHCA welcomes and supports the vision and implementation of *ECFAA* across the health care system, including home and community care. Best evidence and standards of care will be better linked to ensure the efficient use of resources and achieve value for the individuals served.

Sustaining the quality agenda and managing the fiscal challenges will drive a continued focus on "value for money". This means gaining a better understanding of the impact of care provided by the health care team in home and community care over time.

Conclusion

The services offered through home and community care need to be broad, diverse and imaginative so that the critical supports that allow people to function optimally in the community are provided. Health care is a system with interdependencies. Maximising the internal efficiencies within separate health system 'silos' is no longer an effective indicator of a robust home care system. The measures of a transformed health system must reflect improved health outcomes of each individual and of defined populations. These include measurements of effective access and navigation of the community-based resources and improved overall system utilization. How well this shift is made will be critical to meeting the changing needs of people and, indeed, to supporting the financial sustainability of the health care system as a whole. Home care is an important part of the solution.

¹⁰ *The Excellent Care for All Act*, 2010 http://www.health.gov.on.ca/en/legislation/excellent_care/