

# *Care In The Home: Challenges and Opportunities*



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# Acknowledgment

Members of the **COUNCIL ON AGING OF OTTAWA** and the more extensive Ottawa seniors community have repeatedly emphasized the importance of Care in the Home services to their long term health, security and autonomy.

This study was undertaken in response to consistent requests from Ottawa seniors for the Council to do so.

The Council on Aging of Ottawa wishes to express appreciation to all the participating agencies and institutional representatives, and volunteers who shared their knowledge and experience to help us define the issues and shape the recommendations contained in this document.

The names of those who contributed in so many valuable ways, are listed at the end of the report.

The Council on Aging of Ottawa is sincerely grateful for the unique contributions of:

Barbara Schulman, Vice President of Planning and Partnership,  
SCO Health Service who chaired the committee and so effectively kept us on course.

Margaret George, a former Executive Director of the Council on Aging who masterfully took the volumes of data and material and wrote the final report.

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## 1. Introduction

The Council on Aging (COA) is a charitable, non-profit, volunteer organization committed to enhancing the quality of life of seniors within the City of Ottawa<sup>1</sup>. For over 25 years, the COA has been proactive in bringing seniors' issues and concerns to the attention of the public and various levels of government. It is within the context of changing demographics and overall restructuring of the health care system that the COA has analyzed the very important issue of care in the home.

The Council on Aging strongly believes that care in the home must be recognized as an essential component of the health care system and be provided with adequate resources to meet the rapidly escalating demand for services.

Today there are more than 91,000 seniors in the City of Ottawa, 12% of the total population. By 2031 there will be 274,000, nearly 22% of the total. While the entire population is expected to increase by 60% over this period, the number of seniors will triple. Moreover, the fastest rate of growth will be among the oldest members of the senior population. For example, whereas today 11,000 Ottawa residents are 85 and older, by 2031 there will be nearly 39,000, three and a half times as many.<sup>2</sup>

Given the aging of the population, health care planners and economists are now focusing on the logistics and associated costs related to the type of care that will be necessary and where it will be provided. The aging process has major implications for the delivery of health care since seniors are prime consumers of health care services. Compared to younger adults, seniors see doctors more frequently, are hospitalized more often, use more home care services and take more drugs.<sup>3</sup> "In the 1996-97 fiscal year, the 65 and over population was three times more likely to be hospitalized than the population as a whole and for those aged 75 and over it was almost four times"<sup>4</sup>.

Nationwide polls reflect that care in the home is related to quality of life and subjective health status. When asked their opinion, the majority of seniors state that they would prefer to have services delivered in their own home or in the community as opposed to being admitted to hospital or a long-term care facility. Comprehensive care in the home gives seniors choice, the maintenance they require to stay well, and independence which is key to their quality of life. Furthermore, the availability of care in the home is fundamental in preventing premature or inappropriate hospitalization and institutionalization for many individuals. Although most seniors are well and do not require services, the majority of those who need assistance require help with daily activities (such as bathing and meal preparation) and require this assistance over a longer term.

Significant changes are occurring in the way that health care services are organized and delivered. Same day surgery, technological advances and new drugs have made it possible to receive the type of care in the home that formerly was only available in hospital. With the restructuring of the hospital system, increased pressures have been brought to bear on community services and family caregivers<sup>5</sup>.

“The growth in the number of elderly, coupled with the tendency to discharge patients from hospitals at an earlier stage of recovery than in the past, has made the provision of health and other support services to seniors in their homes increasingly more important.”<sup>6</sup> Due to the decrease in hospital beds, patients are being released “quicker and sicker” into the community with the expectation that services will be there when needed. Unfortunately this is not always the case.

Another important consideration is that many seniors live in poverty or near-poverty conditions and a growing number live alone. According to the most recent Census, 13% of Ottawa seniors had incomes below \$10,000 per year and another 35% had between \$10,000 and \$20,000. Moreover, nearly 30% lived by themselves and this percentage has continued to increase with each Census<sup>7</sup>. Low-income and living alone have major implications on accessibility to adequate services and assistive aids necessary to remain safely at home in the community. The reality is there is an increased need for care in the home, but inadequate publicly funded resources to respond. The senior population is increasingly vulnerable and living at risk.

A number of insurance companies have recently started to offer insurance plans for care in the home services, programs intended to provide to the insured supplementary care not offered by the government-sponsored programs. Although these plans may be advantageous, from a financial perspective, for many individuals and couples, they do command high premiums and, because of their complexity, need to be closely scrutinized.

## **2. Who Provides Care in the Home?**

To the average citizen it is very confusing to know who provides what. In essence care in the community comes from four sources: family caregivers; the Community Care Access Centre (CCAC); Community Support Services agencies (CSSs); and other organizations, such as private agencies, health-related societies, and faith groups which are not publicly funded by government.

Care in the home begins with family caregivers. “Up to 90% of the care of elderly in their homes is provided informally, largely by family...”<sup>8</sup> This represents a monumental contribution to the health care system which is often overlooked. The largest provider of publicly funded services in the home are the CCACs which act as a single point of access for a wide range of formal community services and programs (including nursing, therapies and personal support services/homemaking). CCACs assess, plan, coordinate and monitor the delivery of services to support clients and caregivers in their homes, and assess, coordinate and assist clients with applications and admissions to long term care facilities. CCAC services do not have any direct fee to the client due to funding from the Ministry of Health and Long-term Care (MOHLTC). Fee-for-service agencies and several non-profit organizations provide the same services as those provided through the CCAC; however, there is a fee and therefore a problem of accessibility for low income seniors.

CSSs agencies provide services which are complementary to those of the CCAC. These services are

delivered by non-profit, volunteer-based agencies many of which have historical roots in faith group/community sponsorship. Programs include, for example, adult day services, home maintenance, meals on wheels, diners clubs and transportation.<sup>9</sup> While there can be confusion regarding services provided by the CCAC and the CSSs, the former has exclusive responsibility for medical services and much of the latter's focus is on volunteer-based services, such as transportation, yard work, etc. CSSs agencies are funded through many sources including, MOHLTC, municipalities, donations, fund raising and client fees. In Ottawa, for a variety of historical reasons, each of the 24 community support agencies have differing levels of public funding support. Other community agencies and faith groups provide important programs and services but do so without government funding and are often illness-specific associations or provide services which are more limited in scope.

### **3. Issues and Challenges - What are the Problems?**

#### **3.1 Service Delivery and Funding**

From a senior's perspective, improvements to the system are imperative. There are excellent workers in the community who are extremely dedicated and provide quality services; however, despite the best of intentions, care in the home is all too often plagued with many of the following problems:

- **Insufficient levels of service to ensure that seniors can remain safely at home**

The regulations that govern the delivery of CCAC services impose limits on the amount of services an individual can receive. For example, CCACs are allowed to provide a maximum of 80 hours of personal support services (formerly known as homemaking) for the first month and 60 hours/month thereafter. However, some seniors and people with disabilities need more than this maximum in order to be able to remain in their homes. The current budget freezes in the community care sector have made the situation even more problematic. In order to stay within its budget, in October 2001, the Ottawa CCAC had to implement a three-hour reduction in the amount of personal support services it provides to each of its clients per month. More recently, in late December 2001, the CCAC had to take even more drastic measures. As of that date, personal support services are no longer provided to new clients or existing clients who need increased services. Even new high priority clients are not receiving services, but are being wait listed, although exceptions are made whenever fiscally feasible. This situation will remain until at least the end of March 2002.

- **Competing priorities for care**

Frail elderly must now compete with growing numbers of discharged hospital patients and day surgery patients for home care services. CCACs are under pressure to look after post-hospitalized patients as a priority and are now, out of necessity, sending many seniors to other community services and to private fee-for-service agencies.<sup>10</sup> Personal support services (personal care and homemaking) are key in enabling seniors to remain in their homes and are less expensive than many of the other services provided by the CCACs.

- **Shortage of experienced workers**

In 1998, the MOHLTC stopped funding the training for Home Support Worker Level II courses at community colleges, and funded only the more specialized Personal Support Worker (PSW) Level courses. Yet, many of the tasks performed by personal support service agencies only require the lower level of training obtained through the Home Support Level II courses. In order to address the shortages of home support workers, the Ottawa CCAC provided funding for Home Support Level II courses from 1999 to 2001. This practice was discontinued in the 2001/02 fiscal year as the CCAC could no longer afford to continue funding the courses.

The Ministry only funds PSW training for homemakers who already work for agencies or who are doing their clinical placements. New recruits must pay for their own training, and this acts as a barrier to increasing the pool of trained staff.<sup>11</sup>

- **Inadequate continuity of care**

One of the criteria for the provision of quality care in the home is worker consistency. The care provided to a client should, as much as possible, be provided by the same workers, so that a relationship can be established between the person providing the care and the person receiving it. However, many trained workers - personal support workers, nurses and therapists - do not remain in the community care sector because the institutional sector is more appealing to them in terms of wages and working conditions.<sup>12</sup>

- **Inequities and inconsistencies in the availability of services**

As mentioned previously, the evolution of CSSs agencies and the different ways that they are funded has historical roots. Some funds were available at specific times only, while others were available dependent upon where the agency was geographically located due to variations in municipal contributions. This has resulted in inequities and inconsistencies between the services available in different areas of the City of Ottawa as well as between different areas within the province.

- **Lack of specific services, such as respite for family caregivers**

According to the MOHLTC goals for the number of short stay beds, the Ottawa area is under bedded. The September 2001 report by the Champlain District Health Council on Short Stay Care found that there were 22 short stay beds in the Ottawa area. The MOHLTC initially proposed, as a goal, that a number equal to 5% of the long term care beds be dedicated to short stay care. As of September 2001, the complement of 22 short stay beds represented 0.65% of the total long term care beds. The study also identified the need for specific short stay bed programs that meet the needs of persons requiring convalescent care, of caregivers of persons suffering from dementia and of persons with acquired brain injuries and their caregivers. Furthermore, there is a need for beds that can accommodate Francophone clients.<sup>13</sup> In October 2001, as part of its cost containment strategies, the CCAC reduced crisis hours in personal support services to 500 hrs./month; it had been 2000 hrs./month previously. In February 2002, the number of hours was increased to 1000 hrs./month. Despite this increase, it is clear that a higher burden is being placed on family caregivers in the home.

- **Waiting lists for services**

As of December 31, 2001, the Ottawa CCAC had 495 clients waiting for personal support services and 29 waiting for shift nursing. On that date, there were also wait lists for community physiotherapy (119 clients), occupational therapy (299) and social work (46). On the same date the wait time for personal support services was between 3 - 5 months, depending on the client's assessed level of priority.

### **3.2 Effects of Fiscal Constraints**

In theory, the restructuring of the hospital system with its closure of hospitals and in-patient beds was to result in overall savings and a reinvestment in community services. This has not unfolded as planned and the reinvestment into the community has not been sufficient to meet the rapidly escalating need for services. The following are specific areas of concern:

- **Complex and Unmet Care Requirements**

Home nursing and therapy care requirements are becoming more complex and budgets are not growing to keep pace with rising costs. In addition, personal care and home support services are being reduced as a result of budget constraints. These changes are being made despite indications, in recent Canadian research, that these services can make a real difference in a person's health, well-being and quality of life, and that they reduce the need for costlier institutional care.<sup>14</sup>

- **CCAC Cutbacks in Services**

The effect of recent fiscal constraints has been a "downloading" from hospitals to CCACs as acute lengths of stay are shortened and from CCACs to small, volunteer community support programs as access to personal support/homemaking services has been restricted. Due to rapidly increasing demands for services, coupled with the CCACs funding freeze, there will be a 23% reduction in the number of clients served over the 2001/2002 fiscal year. Whereas the Ottawa CCAC provided services to 14,186 clients in March 2001, its client base is expected to be 11,000 in March 2002. Over the same span of one year, there will be a 29% reduction in the number of personal support hours, a 33% reduction in the number of nursing visits and a 25% decrease in the number of shift nursing hours provided.<sup>15</sup> As of October 2001, most clients have received three hours of personal support services per month less than they have been assessed to need.

- **Reductions in Health Promotion and Illness Prevention Programs**

Over the last several years considerable funding has been withdrawn for health promotion and illness prevention programs. As an example, Public Health services to seniors were affected in the 1990's by the province's decision to remove Healthy Elderly as a program standard from the Mandatory Health Program and Services Guidelines. Public Health services were to be integrated throughout all programs. In Ottawa this resulted in a change of emphasis in programming. Formerly 30 FTEs (full time equivalents) were assigned to seniors' public health issues. This evolved gradually to 6 FTEs assigned specifically to seniors' health promotion issues such as Fall Prevention (which remains a mandated program), caregiver support and seniors isolation.

- **Crisis Services - Living at Risk on the Increase**

The City of Ottawa's Health and Social Crisis Program has witnessed an alarming increase in calls for Public Health services for those found in crisis due to serious deterioration in health and living conditions. Approximately half of the clients referred are seniors. In 2000 there were 113 crisis calls, but in 2001 there were 185 crisis calls, a 62% increase.<sup>16</sup>

- **Inadequate Community Support Services**

For Community Support Services, funding has remained at 1992 levels except for a one time 2% cost of living increase in 2000/01 on the MOHLTC portion of the budget. There are significant time and resource pressures for agencies with small numbers of staff and volunteers in fund raising ever increasing proportions of their budgets in a climate of steep competition for donations<sup>17</sup>. Furthermore, the cumulative effect of client fee increases may be affecting low-income seniors' access to community support services. In Ottawa, community support levels (client numbers) have remained relatively stable for close to 5 years, yet the senior population is growing. Anecdotally, agencies point to a lack of adequate resources and capacity to expand services.

Changes have also occurred in access to the Ontario government's Assistive Devices Program. The assessments are more stringent and devices are more difficult to acquire. This has a direct impact on low income seniors.

- **Costs to the Health Care System**

The cost to the health care system for the majority of services for seniors living in the community is much less than the costs to the system if they were occupying a bed in a long-term care facility. For example, the Ottawa CCAC tracked the cost of personal support services provided to clients who were placed in long-term care beds in three of the four facilities with new beds opening in 2001. It was found that the cost of personal support services provided to those clients who had been receiving these services before moving into one of the new long-term care beds varied from a range of \$293 to \$1100 per month. The CCAC, not the client, paid these costs. By way of comparison, the ongoing costs to the Ministry for a long term care bed is about \$1960 per month (effective January 1, 2002). In addition, when clients move to a long term care bed, they start paying the patient's portion of the cost of a bed in a long term care facility. These costs range from \$1,353.73 per month for a ward bed to \$1,901.23 per month for a private bed<sup>18</sup>. Low income persons can receive ward accommodation at a means-tested government-subsidized rate leaving a "comfort allowance" to the patient of \$112 per month.

- **Health Care Expenditures**

Despite the provincial government's claim that health care expenditures are out of control, the following figures illustrate a far different story. Through the 1980-90 decade, per capita health care expenditures<sup>19</sup> in Ontario rose steadily from \$1,227.32 in 1980-81 to a peak of \$1,730.38 in 1989-90. From then on, there was a steady decrease in per capita expenditures until they reached a low of \$1,643.21 in 1997-98. In 1998-99, after eight years of decreases, per capita spending, at \$1,733.89, returned to a level comparable to the 1989-90 level. In the two subsequent years, per capita spending was forecasted to increase by 4.0% (\$1,803.34 in 1999-00) and 6.5% (\$1,921.22 in 2000-01).

These forecasted increases are not surprising in view of the fact that the previous years had seen no growth. Under the circumstances, one can hardly say that health care expenditures are out of control.<sup>20</sup>

### **3.3 Human Resources**

#### **Family Caregivers**

As previously noted, “up to 90% of the care of elderly in their homes is provided informally, largely by family and of that to a large extent by wives, daughters and daughters-in-law. The health system would collapse if they didn’t make the sacrifice”<sup>21</sup>. At the Council on Aging’s Home Care Forum, home care was described by Dr. Pat Armstrong as the biggest conscription of women since World War II. One of the biggest challenges in caregiving is that it is undervalued - it is invisible and is a service, not a product. Dr. Armstrong argued that women can’t do more - they have their paid work and their families as well. In addition, they have their own health problems and often do not have training to provide the level of care required.<sup>22</sup>

These are the facts:

- Because women are called upon to provide more stressful and intensely personal care, more than twice as many female as male caregivers report feeling their caregiving is affecting their own health. They report high stress levels, fatigue, negative emotions, depression, psychological distress, interpersonal conflict, loss of sleep and social isolation.<sup>23</sup>
- Care at home is hard on family relationships. This increase in stress can contribute to family breakdown and violence.
- Care in the home becomes a cost to employers due to increased absence from work and to employees from a loss of income. This further adds to discrimination against women due to the lack of workplace benefit coverage for this activity.<sup>24</sup>
- Many caregivers of seniors are seniors themselves. Senior caregivers often put their own health in peril while looking after elderly spouses.
- There are fewer and fewer family caregivers due to factors such as smaller families, increased mobility, family breakdowns and women working.<sup>25</sup> Furthermore, the pool of family care givers is bound to decline in the future, largely due to changing demographics. While the Baby Boom parents had relatively large families, resulting in a number of children sharing the load of looking after aging parents, the Boomers themselves have few children. Moreover, because of increasing mobility in the labour force, these children are much less likely to be living near their parents, than was the case in the past.

Care in the home begins with family caregivers and the system is failing them. In the 1999 CARP Report, family caregivers were referred to as “silent victims in a silent system.”<sup>26</sup>

#### **Volunteers**

In Ontario, volunteers give 2.5 million hours of service a year to home and community support agencies. Seniors are some of the most generous donors of time - 58% of all volunteers are seniors.<sup>27</sup> In the City of Ottawa in 2000/2001, 3,608 volunteers provided approximately 197,242 hrs. of service to the community LTC service system.<sup>28</sup>

Most CSSs agencies depend heavily on volunteers for the valuable services they provide. Due to the freeze in MOHLTC funding since 1992 for Community Support Services and escalating demands for service, the structure which supported volunteers has been eroded.

Additional issues affecting the volunteer sector include:

- Increasing expectations being placed on volunteers to provide services for which they are not trained and can result in a potential liability to the agency. The role of volunteers is becoming increasingly complex as they assume responsibility more appropriately assigned to staff.<sup>29</sup>
- The volunteer pool is diminishing in size, aging and facing increased risk of burnout.<sup>30</sup>
- Agencies struggle to provide volunteer training and recognition with severely constrained resources and struggle to maintain service levels.<sup>31</sup>
- In recent years there have been changes in the nature of volunteer commitment. It is now easier to attract volunteers for one-time or short-term activities, such as fund raising events, compared to volunteers who provide services over the longer term.
- There appears to be no recognition by the MOHLTC of the enormous contribution and savings to the government that volunteers provide.

### **Professional Workers**

The problems that are affecting the delivery of home care services throughout the province are numerous. The lack of nurses and health care professionals has been well documented. This coupled with the shortage of homemakers and personal support workers has challenged the very viability of care in the home.

The following illustrate some of the factors affecting this situation:

- There is an increased complexity of service requirements, demand, and more recently, a growing proportion of clients with mental health needs. This is due to the aging of the population, as well as limited availability of alternative resources. This has led to increasingly complex case management and service coordination and has resulted in many clients falling through the cracks as service needs cannot be appropriately met.<sup>32</sup>
- The wage disparity between institutional and community work is draining workers away from community care. Low wages contribute to high turnover and problems with continuity of care and service providers. For example, February 2000 reports produced by the Ottawa CCAC on homemaking and nursing shortages<sup>33</sup> found that the average hourly wages of Personal Support Workers who worked in the institutional sector (hospitals and long term care facilities) was over \$4/hr or \$7,000/year more than those who worked in the community care sector. Similarly, there was a \$7,000 to \$12,700 gap between the top, yearly salary rates of Registered Nurses working in hospitals and that generally offered by community agencies. The gap between the salaries of Registered Practical Nurses working in the hospital sector and those working in the community care sector was from \$3,600 to \$7,000 per year.
- In addition, workers find that the working conditions offered in the institutional sector are more appealing. This sector offers job security, regular hours of work, no traveling from one client's home to another and on-site support from other staff.

- In the past few years, agencies have had difficulty recruiting new staff. Agencies have found that new recruits are no longer seeing the home care sector as a career, but rather as a temporary job until they are able to move on to a more lucrative occupation.<sup>34</sup>
- The workforce is aging and there are not sufficient new workers to meet the ever escalating demand for services. According to the Canadian Nurses Association, the current crisis in the shortfall of trained nurses will likely continue to worsen in the near future. Despite the aging of the population, the number of nurses is not growing as fast as the population. Furthermore, the average age of registered nurses is increasingly rapidly;<sup>35</sup> and in Ontario, the pension plan covering the vast majority of nurses has a feature that acts as a disincentive for nurses to continue working past the age of 55.<sup>36</sup>

“Human resource shortages, compounded by wage differentials, are posing serious problems for the home care sector because service providers are finding it difficult to recruit and retain qualified staff; this contributes to waiting lists for services (e.g. homemaking, shift nursing, therapies) and delays in discharging patients from hospital and onto home care.”<sup>37</sup>

## 4. Opportunities and Recommendations

At this point it is crucial for consumers, providers and the general public to advocate for adequate resources to meet present and future needs for care in the home. The recently proclaimed *Community Care Access Corporations Act*, is an initial step in recognizing the pivotal role that CCACs play within the health care system and the importance of care in the home. However, the home and community care system must have adequate resources if it is to fulfill its role. It is important for seniors to understand the fundamental changes that are now being brought forward which will impact on the ways that services are delivered and accessed. The *Community Care Access Corporations Act* can act as a spring board from which politicians, seniors and the general public gain an increased understanding of the importance of all community services which together improve quality of life and enable seniors to remain in their own homes. The Council on Aging of Ottawa is urging all levels of government to work together in developing and supporting a range of services to enable seniors to remain in their homes for as long and as safely as possible.

### **Recommendation #1 - Federal Government**

It is recommended that the essential role of “Care in the Home” as a integral part of Canada’s National Health Care System be reaffirmed through inclusion in the *Canada Health Act*.

### **Recommendation #2 - Federal, Provincial and Municipal Governments**

It is recommended that “Care in the Home” services be resourced more appropriately to reflect changing demographics and location of care.

### **Recommendation #3 - Provincial and Municipal Governments**

It is recommended that the importance of health promotion and illness prevention programs for seniors to reduce future health care costs be reaffirmed and funded appropriately.

**Recommendation #4 - Provincial MOHLTC**

It is recommended that in order to facilitate longer term planning, multi-year, transparent funding be provided to the CCACs and CSS agencies based on a population and needs-based funding model.

**Recommendation #5 - Federal, Provincial and Municipal Governments**

It is recommended that accountability at all levels be integral to the delivery of services to ensure that the needs of seniors are being met.

**Recommendation #6 - Provincial MOHLTC**

It is recommended that the MOHLTC provide the lead and means for the development of databases and outcome indicators in order to ensure accountability through the provision of timely and accurate information.

**Recommendation #7 - The Champlain District Health Council**

It is recommended that in recognition of the complementary role between CSS agencies and the CCAC that a systematic approach be put in place for joint planning.

**Recommendation #8 - Provincial MOHLTC, the City of Ottawa and the Community Support Coalition of Ottawa**

It is recommended that the efforts of the Community Support Coalition of Ottawa be supported in addressing inequities and inconsistencies in community support services between geographic areas within the City of Ottawa.

**Recommendation #9 - Federal Government**

It is recommended that additional support for family caregivers be provided by extending the current caregiver non-refundable tax credit, of benefit only to persons with sufficient income to have a tax liability, to a monthly or quarterly payment to low-income caregivers who at present do not receive any credit for their services.

## **5. Conclusion**

Care in the home is crucial to the success of health reform and to making the overall health care system function more efficiently and effectively. It is central to the health care system because it can often prevent or delay, and substitute for, admission to acute care hospitals and long term care facilities, at a lower cost. Given two clients with the same level of needs, the best value to government comes from supporting the client at home.<sup>38</sup> Since most elderly clients prefer to stay at home for as long as possible, and are highly satisfied with care provided in the home, it is advantageous to both government and clients if the services are there to enable them to stay at home for as long and as safely as

possible.<sup>39</sup>

## End Notes

<sup>1</sup>Seniors are defined as persons over the age of 65.

<sup>2</sup>1. Centre for Spatial Economics, *City of Ottawa, Population, employment, Household and Dwelling Projections, 1996 to 2031*, May 2001.

<sup>3</sup> Federal, Provincial and Territorial Advisory Committee on Population Health, *Statistical Report on the Health of Canadians*. Catalogue No. H39-467/1999E. Ottawa: Health Canada 1999.

<sup>4</sup> Council on Aging of Ottawa, *Fact Book on Aging*, 1999, p.11.

<sup>5</sup> The term “family caregivers” is meant to include family, friends and other caregivers who are not professionals within the health care system.

<sup>6</sup> Council on Aging of Ottawa, *Fact Book on Aging*, 1999, p.24.

<sup>7</sup> Ibid.

<sup>8</sup> Ontario Community Support Association, *In 20 Short Years: A Discussion Paper on Demographics and Aging*, 2001, p.9.

<sup>9</sup> Champlain District Health Council, *Technical Report on Long Term Care Community Support Services in the Champlain District 2000/2001*, December 2001, p.1.

<sup>10</sup> Ontario Community Support Association, 2001, *In 20 Short Years: A Discussion Paper on Demographics and Aging*, 2001, p.3.

<sup>11</sup> Ottawa-Carleton Community Care Access Centre, *Homemaking Shortages Policy Report*, February 2000.

<sup>12</sup> Ottawa-Carleton Community Care Access Centre, *Nursing Shortage Policy Report*, February 2000.

<sup>13</sup> Champlain District Health Council, *Report on Investigation of Short Stay Care in Champlain District*, September 2001.

<sup>14</sup> Home Care/Pharmaceuticals Division, Policy and Communication Branch, Health Canada *Evaluation of the Maintenance and Preventive Function of Home Care. Hollander Analytical Services*, March 2001.

<sup>15</sup> The Ottawa Community Care Access Centre, *Community Care: Perspectives from the Front Lines*, Brief to Helen Johns, Associate Minister of Health on Bill 130 - the proposed Community Care Access Corporations Act, November 2001.

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<sup>16</sup> Discussion with Maryan O'Hagan, Manager, People's Services, City of Ottawa, February, 2002.

<sup>17</sup> Champlain District Health Council, *Annual District Service Plan Technical Report, An Inventory and Examination of Long Term Care Community Support Services in the Champlain District in 1999/2000*, May, 2001, p.3.

<sup>18</sup> The patient rates are fixed by the provincial government and are in effect for the period of July 1, 2001 to June 30, 2002.

<sup>19</sup> Calculated in 1992 constant dollars.

<sup>20</sup> Canadian Institute for Health Information table: *Provincial/Territorial Government Health Expenditures by Province/Territory and Canada - 1974/1975 to 2000/2001 - Constant Dollars*.

<sup>21</sup> Ontario Community Support Association, *In 20 Short Years: A Discussion Paper on Demographics and Aging*, 2001, p.9.

<sup>22</sup> Armstrong, Pat, *Council on Aging of Ottawa, Home Care Forum*, March, 2001.

<sup>23</sup> Ontario Community Support Association, *In 20 Short Years: A Discussion Paper on Demographics and Aging*, 2001, p.9.

<sup>24</sup> Armstrong, Pat, *Council on Aging of Ottawa, Home Care Forum*, March, 2001.

<sup>25</sup> Ontario Community Support Association, *In 20 Short Years: A Discussion Paper on Demographics and Aging*, 2001, p.10.

<sup>26</sup> CARP, Carp Report Card on Home Care, 1999.

<sup>27</sup> Ontario Community Support Association, *In 20 Short Years: A Discussion Paper on Demographics and Aging*, 2001, p.10.

<sup>28</sup> Champlain District Health Council, *Technical Report on Long Term Care Community Support Services in the Champlain District 2000/2001*, December 2001, p.195.

<sup>29</sup> Champlain District Health Council, *Annual District Service Plan Technical Report, An Inventory and Examination of Long Term Care Community Support Services in the Champlain District in 1999/2000*, 2001, p.25.

<sup>30</sup> Champlain District Health Council, *Annual District Service Plan for Community Long Term Care Services in the Champlain District, Current State Analysis Report*, June, 2001, p.25.

<sup>31</sup> Ibid.

<sup>32</sup> Ibid, p.29.

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<sup>33</sup> Ottawa-Carleton Community Care Access Centre, *Homemaking Shortages Policy Report*, February 2000; *Nursing Shortage Policy Report*, February 2000.

<sup>34</sup> Ottawa-Carleton Community Care Access Centre, *Homemaking Shortages Policy Report*, February 2000.

<sup>35</sup> See [www.cna-nurses.ca](http://www.cna-nurses.ca)

<sup>36</sup> See [www.hoopp.com](http://www.hoopp.com)

<sup>37</sup> Ontario Ministry of Health and Long Term Care, *A Review of Community Care Access Centres in Ontario*, Price Waterhouse Coopers, December, 2000, p.vi

<sup>38</sup> This must work within the fiscal reality of resources required dependent upon level of care.

<sup>39</sup> Home Care/Pharmaceuticals Division, Policy and Communication Branch, Health Canada *Evaluation of the Maintenance and Preventive Function of Home Care. Hollander Analytical Services*, March 2001, p.iii.

***The Council on Aging of Ottawa***  
***Le Conseil sur le vieillissement d'Ottawa***

Home Care Task Force & Committee Membership

**From the Council on Aging of Ottawa:**

- ! Chair Joan Skene
- ! Pierre-Paul Demers
- ! Hubert Frenken
- ! Lise Ladouceur
- ! Erin Pollard
- ! Margaret George

**From the Community Care Access Centre:**

- ! Lise Corbeil                      Manager, Planning & Strategic Direction

**From the Community Support Services Coalition:**

- ! Barbara Lajeunesse      Executive Director, Olde Forge Community Resource Centre
- ! Christine Dawson

**From the Hospital Sector:**

- ! Barbara Schulman      Vice-President, Planning & Partnerships, SCO Health Service
- ! Cal Martell                      Director of Geriatric Administration, Ottawa Hospital, Civic Campus
- ! Kathleen Nunn Regional Geriatric Assessment Program

**From the Disabled Persons' Community Resources:**

- ! Danielle Vincent              Community Support Worker

**From the Ottawa Public Health Department:**

- ! Maryan O'Hagan              Senior's Adult Health Program, Health Department, City of Ottawa

**From the Champlain District Health Council:**

- ! Nancy Jaworski              Health Planner

**From the Retirement Home Sector:**

- ! Christina O'Neil              Ontario Association of Non-Profit Homes & Seniors Services
- ! Oris Retallack                      Administrator, Unitarian House of Ottawa

**Bradson Home Health Care Inc.:**

! Penny Sands Director