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Long-term care for the elderly in Canada: progress towards an integrated system

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12.1 Introduction

Hospital and physician services for Canadians of all ages are shared responsibilities of the federal government and the governments of ten provinces and three territories. However, long-term care is regulated, funded and delivered only under the auspices of provincial/territorial governments with no major role for the federal government. Therefore, one cannot accurately refer to the ‘Canadian healthcare system’ as a singular entity. Rather healthcare, and long-term care, is delivered by thirteen different systems with national legislation guiding some, but not all, aspects of service delivery, regulation and administration (Beland and Shapiro, 1994). In addition, healthcare in Canada is provided by a mixture of public and privately funded services, and the balance between those sources of payment varies by region. The complexity of the Canadian healthcare mosaic has increased further with the introduction of regional authorities responsible for ‘local’ management of health services in the last two decades.

Rather than provide an encyclopedic summary of the regulatory structure of healthcare for the elderly in all regions of Canada, this chapter will focus on the experience of the province of Ontario to illustrate the experience of the country’s most populous province. It is also the province with the most fully integrated health information system across the continuum of care for older people, which is intended to improve clinical practice, quality, public accountability and funding of health services. That said, one must remain aware that this overview represents a single province’s experience that shares much, but not all, in common with other regions of the country. The chapter begins with a brief overview of the three levels of government (federal, provincial, regional) that have an influence over healthcare in Canada. The remainder deals specifically with the continuum of care for the elderly in Ontario.
12.2 The wider health system context and the roles of government

The Government of Canada bears national responsibility for health protection and public health, but it provides healthcare services only to selected sub-populations (aboriginal peoples, the Royal Canadian Mounted Police, Canadian Armed Forces and inmates in federal prisons). For the most part, its role is limited to co-payment of provincially managed healthcare services through the 2004 Canada Health Transfer and the administration of the Canada Health Act (CHA), 1984.

The transfer of funds from federal to provincial or territorial governments is subject to compliance with the requirements of the 1984 Canada Health Act (Flood and Choudhry, 2004). That act set national standards to govern the provision of medically necessary physician and hospital services, but it does not apply to home care, nursing homes or pharmacare. The five principles of the CHA are that the covered services must be: (a) publicly administered; (b) comprehensive – covering all medically necessary hospital, physician and surgical dental services; (c) universal – providing equal coverage to all citizens; (d) portable – to ensure coverage if citizens move between provinces; and (e) accessible to allow reasonable access to those services. Policies and regulations related to long-term care services are set only by provincial governments without linkage to the CHA and with no accountability to the federal government.

A federal report on the future of healthcare in Canada prepared by a commission led by a formal provincial premier (Romanow, 2002) recommended a number of additions to the CHA, including the introduction of a sixth principle of public accountability and the inclusion of home care as a type of service subject to the Act. However, both recommendations failed to translate into legislation as a result of considerable opposition from provincial governments. Several provinces established organizations with responsibilities for monitoring healthcare quality and safety. In addition, the Health Council of Canada (HCC) was formed with a mandate to report on progress toward goals established in a 2004 First Ministers’ Accord on health funding.

12.2.1 Ontario healthcare system

According to estimates of health expenditures made by the Canadian Institute for Health Information (CIHI) (CIHI, 2010), the total per
capita expenditure on health in Ontario in 2010 was CAN $1,524 representing about 12.2 per cent of GDP, which is slightly higher than the national expenditures (11.4 per cent GDP). Expenditures on ‘other institutions’, which include nursing homes and similar residential care facilities, accounted for about 10 per cent of total national expenditures (individual provincial rates were not reported by CIHI). Public expenditures represent about two-thirds of Ontario’s total expenditures. Hospitals accounted for 34 per cent of public expenditures, followed by physicians (23 per cent), other health spending (19 per cent) and drugs (10 per cent) (CIHI, 2010). The bulk of private expenditures in Ontario are accounted for by health professionals other than physicians (e.g., dentists, physical therapists) and drug costs (34 per cent and 33 per cent, respectively) (CIHI, 2010). However, medications for the elderly are publicly funded under the Ontario Drug Benefit Program. Drug costs have been the most rapidly increasing source of health expenditures in Canada over the last two decades (Morgan, 2004). Although Ontario has lower per capita expenditures than the Canadian average on hospitals and fewer health professionals per 100,000 population (CIHI, 2009a), it has the highest level of drug expenditures per capita in the country (CAN $346 compared with CAN $308 for Canada as a whole) (CIHI. 2010).

12.2.2 Healthcare funding in Ontario

Ontario began the transition from global funding for healthcare organizations toward case-mix-based funding methodologies with the introduction of Case Mix Groups, a Canadian adaptation of Diagnosis Related Groups (Ladak, 1998) in 1983 as a basis for acute hospital funding. By 2002, the Resource Utilization Groups (RUG-III) case-mix system (Fries et al., 1994; Hirdes et al., 1996) was used in the funding methodology for complex continuing care hospitals.

Until recently, home care has been funded through global budgets allocated to Community Care Access Centres (CCACs). Case managers are expected to contract healthcare services from home care provider agencies without capping services supplied to an individual level while adhering to a prescribed overall case management budget. In 2005 the Ministry of Health and Long Term Care (MoHLTC) and CIHI jointly funded a research project to validate the Resource Utilization Groups.
for Home Care (RUG-III/HC) case-mix system (Poss et al., 2008). A province-wide study of over 440,000 clients demonstrated that the RUG-III/HC would be an appropriate case-mix system for long-stay home care. However, case-mix-based funding has not yet been introduced to that sector.

Long-term care homes in Ontario have been funded with case-mix adjustments since the early 1990s, when the Alberta Resident Classification System (ARCS) was introduced to that sector (Hirdes, 2001). ARCS was a relatively simple classification system with eight groups differentiated primarily on the basis of functional status, continence and behaviour. However, over time, the distributions of ARCS groups within long-term care homes began to converge (for a variety of reasons, including problematic coding practices) such that almost all long-term care residents fell into one of two ARCS categories. By 2010, the ARCS system was abandoned in favour of the RUG-III as the case-mix system for long-term care homes.

12.2.3 Local Health Integration Networks

Most provinces have regional health authorities that provide management and oversight of health services at the local level. The Government of Ontario established fourteen Local Health Integration Networks (LHINs) in 2005 (Ministry of Health and Long-Term Care, 2011c) with the aim of creating an integrated healthcare system that improves quality of care and is more responsive to local needs. The authority and mandate of LHINs are defined under the Local Health System Integration Act, 2006 (LHSIA 2006).

12.2.4 LHIN governance and accountability mechanisms

Each LHIN is governed by a board of directors appointed through a mechanism established by the Ontario government. The relationship between the Ministry and LHINs is governed by an accountability agreement known as a Ministry/LHIN Accountability Agreement (MLAA). The MLAA requires LHINs to: (a) establish performance goals, objectives and standards, performance targets and measures for the network and the local health system; (b) report on the performance of the network and the local health system; (c) plan for spending the funding that the network receives from the Ministry; and (d) establish a
performance management process for the network. In addition to MLAAs, the Ministry and LHINs enter into a Ministry-LHIN Performance Agreement (MLPA) with a focus on system performance and financial accountability (Waterloo Wellington LHIN, 2010). The MLPA includes fourteen performance indicators and LHIN targets and sets out Ministry and LHIN obligations.

Given that the Ministry has entered into accountability agreements with the LHINs, each LHIN, in turn, has entered into accountability agreements with health services providers such as hospitals, long-term care homes, community care access centres (CCAC), community support services (CSS), community health centres (CHC) and community mental health and addiction (CMHA) services. These agreements enable LHINs to provide funding to health services providers for the delivery of health services. They are intended to support ‘a collaborative relationship . . . to improve the health of Ontarians through better access to high quality health services, to co-ordinate healthcare in local health systems and to manage the health system at the local level effectively and efficiently’ (Central East Local Health Integration Network, 2010).

12.2.5 Long-term care settings across the continuum

In each province/territory elderly persons and adults with disabilities receive services from a broad spectrum of community- and facility-based agencies across the continuum of care. While the Canada Health Act reflects the basic components of primary care and hospital services that represented the bulk of healthcare services when publicly funded Medicare was established in the 1960s, the breadth of continuum of healthcare has grown dramatically since that time. The lack of a national legislative framework governing many of the services provided to older adults means that there is tremendous heterogeneity in the structure, intensity and nature of long-term care services provided to the elderly. Ontario shares numerous aspects of its continuum of care with other provinces; however, it is also distinctive in some aspects of long-term care (e.g., model of case management, delivery of post-acute care, separate social services in the community from clinically oriented home care). The remainder of this chapter provides an overview of each of the major components of Ontario’s continuum of care.
12.3 Care for the elderly in Ontario

12.3.1 Long-term care homes

Expenditures on ‘other institutions’, which are primarily comprised of nursing homes, represent about 10 per cent of total Canadian health expenditures. On a per capita basis, Canada spends more than four times as much on institutional care than on home care (CIHI, 2007, 2011). In Ontario, about two-thirds of long-term care homes services are provided on a for-profit basis (facilities owned by private corporations) and the remaining third are provided by not-for-profit organizations (e.g., municipal governments or charitable organizations). The for-profit homes include individual homes owned and managed as a family business, as well as those that are part of corporate chains. There are about 750 nursing homes in the province with 75,000 beds, and the rate of institutionalization of the elderly in 2006 was 6.3 per cent for persons aged 65 and over (Hirdes et al., 2011) compared with 6.7 per cent in 1981 (Forbes et al., 1987).

All long-term care homes are subject to provincial regulation and monitoring. These facilities are licensed by the province. The Ministry of Health and Long Term Care (MoHLTC) provides public funding for the healthcare portion of long-term care home services; however, the user is responsible for a co-payment to cover accommodation costs. In 2010, the co-payment was between CAN $50 and $70 per day (for basic to preferred accommodation) and the Ministry portion was about CAN $90 per day for a total of about CAN $140 per day compared with CAN $997 per day for an acute hospital stay (Ontario Hospital Association (OHA), 2010).

Long-term care homes offer both long-stay (with an indefinite duration) and short-stay (expected to be less than ninety days) accommodation. However, publicly funded short stay beds are very limited in supply and access to privately funded respite beds is only slightly greater. About 6 per cent of residents are discharged within ninety days of admission compared with 57.0 per cent of patients in complex continuing care hospital settings (Hirdes et al., 2011). The median length of stay among persons discharged from long-term care is about 155 days, which is substantially shorter than that in other Canadian provinces. This may be explained, at least in part, by the two to three times higher rate of discharges to hospital in Ontario compared with
other provinces/territories (Hirdes et al., 2011). Given that about half of all discharges from Ontario long-term care homes are to hospital settings, the length of stay differential may reflect regional differences in approaches to end-of-life care in nursing home settings. About one-third of discharges are due to death, and returning to home accounts for only about 1 per cent of long term care discharges in Ontario.

Until recently, there was no provincially mandated standardized clinical assessment system for Ontario nursing homes. Under a previous approach, chart reviews were done by external staff employed by the MoHLTC to document resident characteristics using the Alberta Resident Classification System (Hirdes, 1997). These records were used only for case-mix classification and played no role in care planning or quality improvement initiatives. However, following the mandated introduction of interRAI assessment instruments\(^1\) into numerous other healthcare sectors (Bernabei et al., 2009; Hirdes, 2006; Hirdes et al., 2003), the Resident Assessment Instrument 2.0 (RAI 2.0) and its associated Resident Assessment Protocols (RAPs) for care planning were mandated as the provincial standard for assessment in long-term care homes. The aim was to improve quality of care at the individual and population levels and to provide information that could be used at the facility level to inform the nursing home payment system. All residents in these facilities are assessed within fourteen days of admission and every ninety days thereafter. Data from these assessments are submitted nationally to CIHI’s Continuing Care Reporting System, which is used for national statistical reporting on nursing homes across the country. Implementation of the RAI 2.0 was done on a phased-in-basis beginning in 2005 with complete implementation in all homes by 2010.

12.3.2 Retirement homes and assisted living

Retirement homes and (more recently developed) assisted living facilities are privately funded organizations that have historically been

\(^1\) interRAI assessment instruments are comprehensive clinical assessment tools used as part of normal clinical practice to assess medical, psychosocial and environmental aspects of a person’s functioning (www.interrai.org). They also track interventions, services and medication use. These assessments may be used to support multiple applications for multiple audiences (Hirdes et al., 1999, 2008; Gray et al., 2009), including care planning, outcome measurement, quality monitoring and case-mix-based funding.
accountable to the Ministry of Community and Social Services. Their accountability was transferred to the purview of the MoHLTC in 2008, but they are not subject to the same regulations as long-term care homes and residents bear the full costs for services they provide. Only a portion of these organizations belong to a professional association (Ontario Retirement Centres Association (ORCA)), and there is no requirement for accreditation or external inspection of health services. Growth in the retirement home industry has been substantial, particularly since it is often considerably more profitable than the operation of long-term care homes.

Ontarians can apply directly for admission to retirement homes and there is no minimum level of care required for entry. As a result of sometimes prolonged waiting times for entry into long-term care homes for persons deemed eligible for placement, retirement homes have begun to offer an expanded array of privately purchased health services as an alternative to publicly funded long-term care. The lack of a standardized, mandatory assessment approach for retirement homes and assisted living makes it almost impossible to determine the needs of residents in these settings. However, the belief that these homes house an increasingly frail population with little or no oversight, no public accountability framework and no service quality standards has led to the introduction of proposed legislation for a regulatory authority for these homes (Ontario Government, 2010f). There is a sense that more expensive retirement homes targeting affluent seniors provide good-quality care that may be comparable to or better than long-term care homes, but there is no evidence base to evaluate this assumption. In contrast, anecdotal stories of poor quality in lower-cost retirement homes (Toronto Star, 2010) have become cause for heightened public concern.

12.3.3 Home care

Home care is provided through publicly funded agencies known as Community Care Access Centres (CCACs). These were established to serve as a single point of access to healthcare services in the community, including admission to long-term care homes, in-home services and school services (Ministry of Health and Long-Term Care, 2011a). The authority of CCACs is derived from their designation as placement coordinators under the Long Term Care Homes Act, 2010. In this capacity, placement coordinators determine individuals’ eligibility for
community support services such as home care, transportation, meals-on-wheels or admission into long-term care homes based on criteria set out under the Act.

There are fourteen CCACs in Ontario with geographic boundaries directly aligned with their LHINs. CCACs are funded by the LHINs through the MoHLTC and are accountable for the delivery of services and funding received on the terms and conditions of their respective Multi-Sector Accountability Agreements (MSAAs) (Central East Local Health Integration Network, 2010). CCACs are also governed by the Community Care Access Corporations Act, 2001, which establishes them as service agencies and sets out their mandate, governance and accountabilities (Ontario Government, 2010a). Other legislation that governs CCACs includes: Home Care and Community Services Act, 1994; Health Insurance Act, 1990; Commitment to the Future of Medicare Act; Long-Term Care Homes Act, 2010; and Accessibility for Ontarians with Disabilities Act, 2005.

CCACs serve at least five populations of home care clients: (a) long-stay clients expected to be on service for sixty days or more requiring maintenance level or supportive care; (b) short-stay post-acute clients discharged from hospital, typically requiring wound care, intravenous therapy or other nursing services; (c) rehabilitation clients requiring short-term physical or occupational therapy; (d) palliative home care clients, half of whom are expected to live six months or more; and (e) medically fragile children receiving care at home or in school settings. Case managers are responsible for evaluating the needs of all types of clients, and they contract services (mainly personal support/homemaking, rehabilitation and nursing) with home care provider agencies through a competitive bid process. Successful home care service providers enter into accountability agreements with CCACs for the delivery of these services.

In 2009–10, approximately 603,000 Ontarians received approximately 29.4 million visits/hours of care at home (Ontario Home Care Association, 2011). These included personal support/homemaking (69 per cent), nursing (26 per cent) and therapy services (5 per cent). While case management and the contracted services provided through CCACs are fully funded by the MoHLTC, many Ontarians choose to supplement CCAC allocated services with privately purchased home care services. These supplemental services include clinical services by licensed health professions (e.g., physical therapy, nursing) or unlicensed personal support services. These supplemental services may be
paid by ‘privately-insured employment and/or government programmes (such as respite programmes) and/or direct private purchase’ (Ontario Home Care Association, 2011). It is estimated that the 150,000 individuals in Ontario ‘purchase an additional 20 million visits/hours of home care services annually in order to remain at home’ (Ontario Home Care Association, 2011).

Due largely to economic constraints, the number of individuals served by home care agencies fell by about 2.8 per cent from 2005–2006 to 2009–2010. However, the total number of units of services in the same period has increased 14.2 per cent, indicating an increase in the care demands of the smaller home care population receiving services in later years (Ontario Home Care Association, 2011). Although nursing visits, personal support services and homemaking increased in that time period, rehabilitation services, including occupational therapy, physiotherapy and speech-language therapy visits declined by 9.1 per cent (Ontario Home Care Association, 2011).

12.3.4 Admission and assessment processes

Following its mandated adoption in 2003 as the standard assessment system for home care, case managers assess long-stay home care clients with the RAI-Home Care (RAI-HC) (Canadian Home Care Association, 2008) on intake and every six months thereafter in order to determine service eligibility and needs. In addition to allocation of home care services, CCAC placement coordinators also are responsible for the nursing home placement process. The RAI-HC (or Hospital version of RAI-HC if the client is in hospital) is used to inform decisions about nursing home eligibility and priority levels for admission. Although case managers may support clients who are admitted into retirement homes, those facilities do not require an assessment for entry. As mentioned above, historically, retirement homes were governed by another ministry and were not regarded as ‘healthcare facilities’. The evolution of retirement homes into unregulated alternatives to nursing homes will probably result in a change in these practices over time.

Persons who seek admission to a long-term care home must contact the CCAC in their geographic community. Placement coordinators determine eligibility for long-term care home admission by criteria set out in Section 155 of Regulation 79 under the Long Term Care Homes Act, 2010 (LTCHA). The criteria for long-stay residency include:
(1) the person is at least 18 years old; (2) the person is an insured person under the Health Insurance Act; (3) the person requires nursing care be available on-site 24 hours a day, requires, at frequent intervals throughout the day, assistance with activities of daily living, or requires, at frequent intervals throughout the day, on-site supervision or on-site monitoring to ensure his or her safety or well-being; (4) the publicly-funded community-based services available to the person and the other caregiving, support or companionship arrangements available to the person are not sufficient, in any combination, to meet the person’s requirements; and (5) the person’s care requirements can be met in a long-term care home (Ontario Government, 2010e).

Nursing homes have the right to refuse a resident who has applied for admission; however, the right to refuse is not open-ended. Concerns about potential behavioural problems are a relatively common reason for refusal of potential residents, and these individuals often experience prolonged hospital stays because of difficulties in gaining admission to long-term care.

To date, there have been no mandated CCAC assessments for short-stay post-acute or rehabilitation clients. If these individuals remain on service for more than sixty days they receive a RAI-HC assessment. However, in 2010 CCACs began province-wide implementation of the interRAI Contact Assessment (CA) as a preliminary screening assessment for all home care clients at the first point of contact to determine their need for more comprehensive assessment with RAI-HC. While the RAI-HC has been used for about 200,000 assessments per year to date, the interRAI CA is expected to be applied to over 400,000 intakes annually. In addition, CCACs began implementation of the interRAI Palliative Care (interRAI PC) (OACCAC, 2011) in 2011 as the standard assessment for all community-based palliative care services managed by CCACs. This also includes some services offered by CCACs to persons in residential hospices. Hospice care in Ontario is provided by community-based volunteer organizations funded by LHINs to provide a range of compassionate end-of-life support and care to persons living with a life-threatening illness and their families. Hospice services include respite care, drop-in programmes and outreach, education and bereavement counselling. For pain and symptom management, professional services, including medicine and nursing, are available from and funded through CCACs. Additional funding is raised through fundraising and benefactors. While some hospice programmes stand alone, others are integrated into other service organizations.
12.3.5 Community Support Agencies

There are over 800 community support agencies across Ontario that provide services to a lighter-care community-based population than typically seen by CCACs. However, there is considerable overlap between the populations targeted by each, and it is not uncommon for frail older adults to receive services from both. Both types of agency are accountable to the Ontario MoHLTC. The main aim of community support agencies is to help older adults and persons with disabilities remain independent and to continue to live in their homes and communities (Ministry of Health and Long-Term Care, 2011b). These agencies are fully or partially funded by the provincial ministry. The services that they provide include: professional services, personal support and homemaking, meals, community transportation, acquired brain injury services, assisted living services in supportive housing, and elderly persons’ centres (Ministry of Health and Long-Term Care, 2011b). Individuals can access these services directly through self-referral.

In 2010, community support agencies were mandated to use the interRAI Community Health Assessment (CHA) as the standard assessment for their caseload, unless the person is already assessed with RAI-HC. A lack of coordination and communication between some CCACs and community support agencies is a current problem affecting business processes for assessment practices and information sharing. In addition, because they are considered community support agencies, some hospices are currently implementing the inter-RAI CHA system rather than the interRAI PC, even though it would be more clinically appropriate to adopt the latter instrument.

12.3.6 Hospital-based care

Hospitals are subject to the terms of the Canada Health Act, 1984. As such, they are managed under the direction of public boards of directors and the majority of their services are funded by the MoHLTC with no additional fees to the patient. However, a co-payment equivalent to that charged for basic nursing home services (about CAN $50) is levied on patients declared by the attending physician to require an Alternative Level of Care (ALC). ALC patients are those who no longer have a condition requiring acute care, but they are not considered able to
return home safely. They therefore typically are awaiting placement in a long-term care home. ALC patients are typically elderly, but they may include persons with disabilities or mental health needs combined with chronic health conditions that limit their ability to live independently. Other non-ministry revenues include relatively modest commercial sources such as parking fees and gift shop sales. In 2010, 86 per cent of hospital revenues came from the MoHLTC, and 68 per cent of their expenditures were for compensation and benefits. The balance of expenditures was roughly equally divided between equipment, medical supplies, drugs, general supplies and other expenses (OHA, 2010).

The share of national expenditures accounted for by hospitals has fallen from almost half of total health expenditures in 1975 to about 25 per cent in 2010. Nonetheless, it remains about 2.5 times greater than expenditures on nursing homes and about double the expenditures on physicians (CIHI, 2011). Ontario has the lowest rate of age-standardized acute in-patient hospitalization at 7,160 per 100,000 compared with 7,837 for the national average (CIHI, 2010). The average length of stay in acute hospitals is 6.4 days in Ontario, compared with 7.7 days in other provinces (OHA, 2010). Rates of emergency department visits in Ontario have declined somewhat from 454 per 1,000 population in 1997 to 431 per 1,000 population in 2009 (OHA, 2010).

There are four types of hospital beds in Ontario that are available either in a stand-alone facility or in specialized units within acute care hospitals. In 2010, there were 18,355 acute hospital beds staffed and in operation compared with 5,798 complex continuing care (CCC), 4,335 psychiatric and 2,322 rehabilitation hospital beds. The supply of rehabilitation and psychiatric beds rose by 13 per cent and 70 per cent, respectively, whereas the supply of CCC and acute beds fell by 50 per cent and 45 per cent, respectively between 1990 and 2010 (OHA, 2010).

12.3.6.1 Complex Continuing Care Hospitals/Units

Complex continuing care (CCC) hospitals/units provide care to medically complex frail older persons who do not require acute hospital services, but are too medically unstable to go to long-term care homes. The number of CCC beds dropped substantially in the last two decades as a result of a change in the role of these facilities. In the early 1990s there was a sense that there was too much overlap in the populations...
covered, and services provided, by CCC hospitals/units and long-term care homes. The Health Services Restructuring Commission (1996–2000) engaged in an extensive review of all health services in the province. It recommended a reorientation of CCC service to place a greater emphasis on rehabilitation and medically complex populations with the majority of lighter-care patients to be redirected towards long-term care homes (Hirdes et al., 2003). A comparison of case-mix distributions in these facilities also shows a pronounced reduction of the percentage of patients with light care needs in response to the directives of the Commission.

Since that time lengths of stay in CCC hospitals/units have declined dramatically as the emphasis switched towards short-term post-acute care (CIHI, 2004). In the early 1980s the average length of stay in chronic hospitals was over two years, but by 2011 the average length of stay among discharges was ninety days with a median length of twenty-nine days. More than half of CCC admissions are discharged within ninety days and about one-third of those discharges are persons returning to their homes (Hirdes et al., 2011).

As part of the process of restructuring the mandate of CCC hospitals/units there was an interest in establishing a case-mix-based payment system that would reflect the resource requirements of patients in post-acute hospital settings. Following an extensive review by the Ontario Joint Policy and Planning Committee (JPPC), the Resident Assessment Instrument (RAI 2.0) (Hirdes et al., 1997) was mandated in 1996 as the standard assessment for CCC settings in order to support the introduction of the Resource Utilization Groups (RUG-III) case-mix system (Fries et al., 1994). The assessment is done on admission and on a quarterly basis; however, only basic tracking and disposition information is gathered at discharge.

Although the RAI 2.0 was originally designed to be used to support clinical practice and care planning, it was mainly introduced as a case-mix tool for funding purposes. By 2002, the provincial funding formula included a modest case-mix adjustment for CCC; however, the RUG-III case-mix system is now being more fully incorporated into the province’s Health Based Allocation Method (HBAM) payment system that is being introduced across multiple healthcare sectors.

About four years after its implementation in CCC settings, the RAI 2.0 and its associated quality indicators (Jones et al., 2010; Mor et al., 2003) began to be used to support greater public accountability in that
sector. The Hospital Report (OHA, 2003) initiative was a partnership of CIHI, the JPPC, OHA and the MoHLTC, which produced the first public, balanced score card on the performance of different types of hospitals in Ontario. By 2003, the first hospital-specific data were publicly released on CCC hospital performance with respect to issues like restraint use, pressure ulcers and functional decline. In subsequent years, both CCC hospitals/units and long-term care homes have RAI 2.0 quality indicators publicly reported by Health Quality Ontario (see below).

12.3.6.2 Psychiatric hospitals/units
Psychiatric hospitals/units in Ontario provide a broad range of inpatient mental health services to populations of all ages, including acute, forensic, long-stay and geriatric psychiatry. Persons aged 65 and over comprise about 14 per cent of the psychiatric hospital population (CIHI, 2009b); however, there are two distinct elderly populations: (a) community admissions with mental health needs comparable to the general adult population; and (b) admissions from long-term care homes that tend to have severe behavioural disturbances. Although discharges to psychiatric hospitals account for only about 1 per cent of long-term care discharges, these individuals comprise the bulk of patients in geriatric psychiatry units in those hospitals. In addition, there are notable differences in length of stay between older persons admitted to psychiatry from community and long-term care home settings. The median length of stay for the general adult population is eight days in psychiatric units in general hospitals compared with twenty-four days in specialty psychiatric hospitals (CIHI, 2009b); however, the median length of stay for elderly patients ranges from about ten days for those aged 65+ in acute psychiatric units to thirty-five days in geriatric units and fifty-seven days in long-stay units. About 75 per cent of discharges among those admitted to in-patient psychiatry from long-term care homes return the person to a nursing home setting (CIHI, 2009b).

All persons admitted to an adult mental health bed in Ontario are assessed with the RAI-Mental Health (RAI-MH) (Hirdes et al., 2001; Hirdes et al., 2002; Martin et al., 2009) on admission and discharge. In addition, those with stays longer than ninety days are reassessed on a quarterly basis. The RAI-MH was developed to support clinical practice, quality monitoring and case-mix classification through a
collaborative research project between interRAI, the JPPC and the MoHLTC. It was mandated for use in all adult psychiatric in-patient settings in 2005. To date, over 400,000 assessments have been completed. The System for Classification of In-patient Psychiatry (SCIPP) case mix system will be incorporated into the HBAM payment system to inform funding decisions for mental health services, including geriatric psychiatry.

12.3.6.3 Acute hospitals
Acute hospitals provide general hospital care to an increasingly elderly population in Ontario. By 2009–10, elderly persons accounted for about 38 per cent of acute hospital discharges (CIHI, 2011), even though they represent only about 13 per cent of the population. The majority of older persons have relatively straightforward health needs that are managed effectively through hospital and they are then discharged home in a relatively predictable manner. However, Alternate Level of Care (ALC) patients have been a major concern in Canada because of the belief that they impede flow through the hospital and cause overcrowding of emergency departments (CIHI, 2009c; Costa and Hirdes, 2010). The designation as ALC is based on a physician judgement that the person no longer needs acute care, and the person requires care in another setting (typically a long-term care home). However, there is not a clear operational definition that is reliably administered across the province, resulting in substantial facility-level variations that may reflect definitional rather than clinical differences (Costa and Hirdes, 2010).

A reduction of ALC days has been an important policy priority in the last five years, but progress has been relatively modest in that time. This is due to a variety of factors, including an increase in the length of time for admission to long-term care homes among those who have been assessed as requiring that level of care (Health Quality Ontario, 2011). As part of a CAN $1 billion investment in community services, the province’s Aging at Home Strategy was introduced in 2007 as an initiative to support independent living of seniors in Ontario. However, by the second year of the strategy, much of its funding was reallocated to support initiatives aimed at reducing ALC days in hospitals. One promising initiative known as ‘Home First’ involves supporting a return to the community from hospital prior to making decisions about long-term care placement.
The intent of this type of programme is to increase the possibility of return to the person’s home with appropriate supports and to remove the pressures of decision making in a hospital environment. It is expected that future provincial quality reports will use the percentage of long-term care home admissions directly from hospital as an indicator of health system quality.

Persons in acute care hospitals who have been designated as ALC patients awaiting nursing home placement are assessed by CCAC case managers with an adapted ‘Hospital version’ of RAI-HC. However, the assessment is currently used only for placement purposes and clinical findings are not shared with hospital staff and care plans are generally not developed in response to the assessment. This means that an important opportunity to improve outcomes for hospital-based frail older adults is often missed.

Costa and Hirdes (2010) provide a comprehensive comparison of ALC patients and long-stay home care clients using Hospital RAI-HC and RAI-HC data, respectively. The ALC population is substantially more impaired in domains like functional status, cognition and continence, compared with the general home care population. In addition, they have notably higher rates of mental health problems including depressive symptoms and behaviour disturbance.

Persons discharged to home care from hospitals are assessed in hospital by CCAC case managers using the interRAI Contact Assessment to determine the urgency of their need for initiation of service provision and the need for comprehensive assessment. In addition, the assessment is intended to provide a basic clinical assessment of persons with less complex needs that may not receive the full RAI-HC assessment. Implementation of the interRAI CA began in 2010 with most CCACs completing the implementation phase in 2011. CIHI added the capacity to manage and report on both the Hospital Version of the RAI-HC and the interRAI CA as part of the Home Care Reporting System. CIHI’s Discharge Abstract Database and National Ambulatory Care Reporting System have both been important sources of information on acute hospital and emergency department utilization for persons of all ages, including the elderly. However, the interRAI instruments provide a more comprehensive clinical view of older persons than those two systems. In addition, they provide the first assessment and screening systems in acute hospitals compatible with those used in other sectors.
12.3.6.4 Rehabilitation

Rehabilitation services are provided through a variety of organizations with different types of funding, oversight and accountability. Physical, occupational and speech language therapists are all regulated health professionals accountable to colleges governing professional practice. Rehabilitation assistants are not currently licensed, although formal educational and credentialling programmes are emerging. A College of Kinesiologists of Ontario was recently established to regulate that discipline; however, no comparable college exists for rehabilitation assistants.

Acute, CCC and stand-alone rehabilitation hospitals provide a full range of physical therapy, occupational therapy and speech language pathology services that are publicly funded and delivered directly by the hospitals. Designated rehabilitation beds represent about 8 per cent of all hospital beds in the province. Rehabilitation departments in hospitals tend to be staffed mainly by licensed therapists. In contrast to hospital settings, access to rehabilitation in long-term care homes has been relatively limited historically. In part, this was a consequence of the Health Services Restructuring Commission directive for rehabilitation services to be provided in hospital settings rather than long-term care. However, it is being increasingly realized that residents of these homes have rehabilitation potential which has not been met with commensurate service provision. Recent legislation has been put in place to expand access to restorative care in long-term care homes (Ontario Government, 2010c, 2010e). The relatively modest level of rehabilitation provided in these homes has come from external agencies contracted by CCACs to provide a limited number of visits or from external for-profit rehabilitation provider companies. On average, long-term care residents receive less than five minutes of rehabilitation per week and over 90 per cent of that therapy comes from aides rather than licensed rehabilitation professionals (Hirdes et al., 2010; Hirdes et al., 2011).

In community-based settings, home care provider agencies may be contracted through CCACs to provide in-home rehabilitation services for long-stay home care clients, but these are typically capped at four visits after intake. Only about 10 per cent of long-stay home care clients receive physical therapy or occupational therapy, and about 75 per cent of those considered to have rehabilitation potential do not receive these therapies (Hirdes et al., 2004; Dalby et al., 2005). Moreover, according
to the Ontario Home Care Association (OHCA, 2010) access to publicly funded rehabilitation in Ontario has declined in home care settings with a drop of 9 and 25 per cent in physical therapy and occupational therapy visits contracted by CCACs, respectively. A recent report commissioned by the MoHLTC (Walker, 2011) called for the expansion of ‘Assess and Restore’ service to help improve the independence of the elderly and reduce the burden of ALC days in acute hospitals. However, the lack of a coherent approach to rehabilitation to date was noted as an important barrier, and several recommendations dealt with the need to establish clear programme standards and admission criteria for these services.

12.4 Health Information Systems and public reporting across the continuum of care

The interRAI family of assessment instruments (Hirdes et al., 1999, 2008; Gray et al., 2009) have become the de facto national standards for assessment in home care and nursing home settings in Canada. Eight provinces and territories are implementing interRAI instruments for those two settings, and several of them are also in the process of adopting other instruments (e.g., interRAI Contact Assessment, interRAI Palliative Care). The remaining provinces/territories currently use locally developed solutions unique to their region. Health Canada, the federal Department of Health, is now exploring using the RAI-HC with First Nations and Inuit populations on a national basis. Compared with other jurisdictions in Canada and internationally, Ontario has the most extensive implementation of interRAI instruments, covering home care, nursing homes, CCC hospitals, psychiatric hospitals, community support services, deaf, blind intervenor services and community-based palliative care (Hirdes, 2006). Ontario was the first province to adopt an interRAI instrument with the mandated use of the RAI 2.0 in CCC hospitals/units beginning in 1996. In addition, it has collaborated with interRAI in the development of new instruments and applications, including the RAI-Mental Health and interRAI Contact Assessment.

A major consideration in Ontario’s adoption of numerous interRAI instruments has been recognition of the value of an integrated health information system based on assessments with common standards across care settings. The interRAI instruments are unique because they share common items, terminology, assessment methods, outcome
measures and care planning protocols across multiple care settings (Gray et al., 2009). In addition, the possibility of using data from interRAI assessments for multiple applications serving multiple audiences has been an important feature of interest to Ontario policy makers. A recent initiative led by the MoHLTC to establish an Integrated Assessment Record (IAR) has the promise of more fully exploiting the use of multiple interRAI assessments as a common clinical record. The IAR will function as a common registry of all mandated assessments for an individual, which can then be accessed by clinicians to obtain a longitudinal view of the person’s status. The IAR is expected to be fully operational in 2013.

At the national level, the Canadian Institute for Health Information compiles data from interRAI as part of the Continuing Care Reporting System (CCRS) (www.cihi.ca/ccrs) and Home Care Reporting System (HCRS) (www.cihi.ca/hcrs) to support national statistical reporting on residential and community-based long-term care. In addition, the Ontario Mental Health Reporting System (OMHRS) (www.cihi.ca/omhrs) serves a similar function for in-patient mental health data from Ontario and interRAI Community Mental Health data from Newfoundland. CIHI produces standard reports to submitting organizations that allow them to compare themselves with regional, provincial and national indicators. In addition, those organizations can access facility-identifiable data through CIHI’s electronic portal to support internal quality improvement initiatives. CIHI also produces substantive reports from the data housed in CCRS, HCRS and OMHRS that are released to the general public as ‘Analyses in Brief’. In addition, participating organizations can access restricted databases for limited facility-level comparisons that are not publicly available. CIHI reports tend to receive extensive media coverage, so they play an important role in raising public awareness about the quality of residential and community services in Canada. Some recent examples include reports on caregivers in home care, restraint use in psychiatry and depression among nursing home residents.

There is currently no national standard survey dealing with personal preferences, satisfaction or the ‘patient experience’. Several pilot studies have been conducted, but most uses of these surveys remain at the local or individual province level. For example, Ontario CCACs have adopted a common client survey that was implemented in all regions by 2012. The survey is administered by an external polling firm and
involves random samples of discharged clients on a quarterly basis and annual samples of active clients. End-of-life clients are excluded from the survey pool; however, there are plans to expand the survey process to current caregivers and family members of deceased clients.

12.5 Improving quality of care in home care and long-term care

Improvement of health system quality and accountability has been a priority for health policy makers and service providers nationally for at least the last two decades. Ontario has played a leadership role in this area with the introduction of clinical data standards, creation of public reporting mechanisms, and establishment of accountability agreements with health service professionals. Quality improvement is regarded as a shared priority and responsibility of numerous stakeholders in the province, and the mechanisms to improve quality are multifold.

12.5.1 Regulatory framework and inspection of long-term care homes

In Ontario, the primary regulatory framework for the quality of care and quality of life of residents in long-term care homes is provided by the Long Term Care Homes Act (LTCHA), 2010 (Ontario Government, 2010c). An overarching fundamental principle of the Act is that ‘a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met’ (LTCHA, 2010, Section 2). This fundamental principle guides the application and administration of the Act.

The LTCHA and its regulations provide several measures for safeguarding residents from abuse, neglect, or risk of harm, including a:

- bill of rights;
- mechanism for the reporting of improper treatment or care that result in harm or a risk of harm to a resident, abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to a resident, and unlawful conduct that resulted in harm or a risk of harm to a resident; and
- mechanism for the reporting and investigation of complaints.
12.5.1.1 Standards of care, services and programmes
The LTCHA and its regulations set out requirements for safety and security, including locking devices for doors and stairways, use of elevators, floor space for both residents and staff, furnishings, privacy curtains, bed rails, communication and response systems, use of generators and lighting and temperature control systems. Specific services and programmes include nursing and personal support services, falls prevention and management, skin and wound care, continence care and bowel management, pain management, care and management of residents with behaviour problems, restorative care, recreational and social activities, nutrition care and hydration programmes, weight management, dietary and food services, medical services, religious and spiritual practices, accommodation services such as housekeeping, laundry and maintenance and volunteer programmes.

12.5.1.2 Compliance inspection and enforcement
Trained inspectors, who are registered nurses, registered dietitians and environmental health specialists by profession, inspect long-term care homes to ensure their compliance with the requirements set out in the LTCHA and its regulations. These inspectors are appointed by the Minister of Health and Long Term Care. Every long-term care home must be inspected at least once annually on a randomized schedule. With a few exceptions (e.g., inspections for compliance with a closure plan), all inspections occur without prior notice.

The Long-Term Care Home Quality Inspection Program (LQIP) provides the structure and process for the inspection of long-term care homes. Under this scheme, inspectors conduct structured interviews with residents, family members and staff members. They make direct observations of how care is provided, and review residents’ records of personal health information (including RAI 2.0 assessments and facility-level reports). Inspection Protocols are used to evaluate compliance with specific aspects of care or treatment. Some examples of Inspection Protocols include: continence care and bowel management, falls prevention, restraint minimization, pain management and skin and wound management. All non-compliances are documented and reported to the long-term care home.

The severity and scope (i.e., pervasiveness throughout the long-term care home) of the non-compliance, and the long-term care home’s history of compliance determines inspectors’ decisions or actions.
These actions range from a voluntary response to correct minor issues to more extreme responses including: ordering that funding to be returned or withheld, ordering the licensee to retain one or more persons acceptable to the director to manage or assist in the management of the long-term care home, and making an order revoking the licence for the operation of a long-term care home.

12.5.1.3 Complaints reporting and investigation
The LTCHA requires long-term care homes to have written procedures for making complaints and to post these procedures where people can see them. Long-term care homes are required to acknowledge a complaint within ten business days where possible and to advise the complainant when a resolution could be expected. Complaints or incidents involving abuse or neglect of residents must be investigated immediately. All written complaints must be forwarded to the designated director under the LTCHA.

An alternative approach available for making complaints is a toll-free ACTION Line established by the MoHLTC. Residents, family members, employees of the long-term care home, anyone providing services to the resident or any member of the general public may call the ACTION Line with their complaints or concerns. Any information that is received by the director pertaining to improper treatment that resulted in a risk of harm to a resident, abuse or neglect of resident, unlawful conduct, or any apparent retaliation against a resident for reporting or disclosing to the director or an inspector, is investigated by a compliance inspector.

12.5.2 Accreditation of health services
Accreditation Canada is a not-for-profit national organization independent of government and health service providers (Accreditation Canada, 2011). It provides peer review evaluation of organizations’ performance in Canada and internationally based on standards set by expert advisory committees. It also provides education services on accreditation standards and processes, patient safety and quality.

The accreditation process is tailored to different types of organizations and provides different standards for over thirty sectors including hospitals, home care and long-term care homes. In 2010, long-term care homes were the most common site for accreditation surveys (34 per
cent) followed by acute hospitals (18 per cent). Home care agencies accounted for 9 per cent of accreditation activities that year (Accreditation Canada, 2010). Organizations interested in being accredited contact Accreditation Canada and request to be accredited. Accreditation surveys are peer reviews conducted by experienced members of health and social service professions (e.g., physicians, nurses, occupational therapists, social workers) and health executives. The focus of accreditation surveys is patient safety and quality practices.

Accreditation Canada surveyors assess the performance of organizations against national standards related to governance, administration, clinical practice and risk management. Surveys usually take several days depending on the size of the organization. Organizations may be awarded full accreditation after the survey, but typically they receive accreditation contingent on conditions specified by the surveyors. In 2010, only 3 per cent of organizations surveyed in Canada and internationally were not accredited.

In addition to Accreditation Canada, long-term care homes could also receive accreditation from the Commission on the Accreditation of Rehabilitation Facilities (CARF) as of October 2008. CARF’s accreditation consists of a two-step process: (1) a self-assessment by the organization; and (2) an external third-party peer review (CARF International, 2011). CARF supports organizations such as long-term care homes that are interested in being accredited through coaching to initially complete a self-assessment of their care and services against CARF’s applicable standards. Following this step, and based on this self-assessment, the long-term care home endeavours to conform to CARF’s standards for a period of six months. Once the long-term care home demonstrates a substantial conformance with CARF’s standards, the organization is ready for the next phase, which is an accreditation survey by a team of external peer surveyors from their own field. Recommendations are identified by the surveyors. The long-term care home is required to submit a Quality Improvement Plan (QIP) to CARF to show how it will address the gaps identified (CARF International, 2011). CARF’s accreditation awards include: (1) three-year accreditation for full conformance; (2) one-year accreditation for conformance with many standards; (3) provisional accreditation for organizations which after one year are still functioning at the one-year accreditation level; (4) non-accreditation for major deficiencies, which impose a risk to the health, wellness or safety of those served.
12.5.3 Professional associations and quality improvement

The professional associations for each major sector of healthcare also play important roles in quality improvement and accountability of the healthcare system. While each association serves an advocacy role acting on behalf of its member organizations as stakeholder representatives interacting with the MoHLTC, these associations also engage in broader activities that have an impact on healthcare quality.

Long-term care homes in Ontario typically belong to one of two professional associations – the Ontario Long Term Care Association (OLTCA) representing the for-profit providers and the Ontario Association of Non-profit Homes and Services for Seniors (OANHSS) representing the not-for-profit homes. Both associations participate actively in provincial-level working groups or committees, and they also host annual conventions that include quality improvement as a major focus. Recently, OLTCA launched a Quality Improvement Recognition Program for organizational achievements in quality improvement.

The Ontario Hospital Association (OHA) represents all hospitals in the province. The OHA and Ontario Medical Association have been the most influential voices affecting Ministry policy. The OHA supports a broad range of educational activities for its members, hosts the largest annual healthcare conference in Ontario and supports a variety of applied research efforts in collaboration with other organizations. For example, in 2000 the OHA and MoHLTC launched the Hospital Report collaborative, representing the first major initiative to provide facility-level balanced score cards to report on the performance of the hospital sector. Recently, the OHA established a strategic alliance with the Ontario Association of Community Care Access Centres (OACCAC) to increase the level of collaboration between the hospital and community care sectors.

The OACCAC is the professional association representing Community Care Access Centres. In addition to its work representing those stakeholder organizations, OACCAC provides IT services and reporting for all home care agencies. It manages the Client Health and Related Information System (CHRIS), which is the provincial home care information system, including data for multiple interRAI assessment instruments and administrative data. OACCAC provides internal decision support services and sets IT standards for all CCACs in the province. It manages the RAI-HC, interRAI CA and interRAI PC data.
in the province and it has the authority to mandate province-wide assessment practices within CCACs. As part of its information management role, OACCAC has also begun to release public reports on the quality of home care and it led to the creation and implementation of a common client experience survey. At its annual meeting the OACCAC also recognizes outstanding organizational performance through its Awards for Excellence Program.

Home care and community support service providers are represented by the Ontario Home Care Association (OHCA) and Ontario Community Support Association (OCSA), respectively. Both organizations host annual professional conferences that include information on innovations, quality-related initiatives and educational programmes. OHCA members are expected to adhere to the Association’s Standards for Home Healthcare Service Agencies. In addition, they conduct an annual self-evaluation of adherence with those standards using the OHCA Quality Template. This template is intended to function as a publicly reported balanced scorecard measuring four dimensions of service: customers, learning and growth, internal business, financial management.

12.5.4 Health Quality Ontario

Health Quality Ontario (HQO; Ontario Government, 2010d) was established as an independent, arms-length agency under the Commitment to the Future of Medicare Act on 12 September 2005, and its mandate was later expanded under the Excellent Care for All Act, 2010 (Ontario Government, 2010b). In its current role, HQO is charged with three major responsibilities:

(a) monitoring and publicly reporting on the quality of care with a particular focus on access to public services; health human resources; consumer and population health; healthcare outcomes across care settings, including home care, long-term care homes and hospitals;

(b) supporting continuous quality improvement (for example, through the Residents First initiative that provides quality improvement education to long-term care homes);

(c) promoting evidence-informed care by providing recommendations on clinical practice guidelines and funding for healthcare and medical devices.
Since 2010, HQO has published public reports on health system performance and quality for long-term care homes, CCC hospitals and CCACs (HQO, 2011). These reports provide information at least at three levels: overall health system performance with no disaggregation of results; LHIN-level findings; and organization-specific results that may be searched through the Internet. The HQO reports use a variety of administrative databases, but they also employ clinical data gathered through the various interRAI assessment instruments mandated for different healthcare sectors. Many of HQO’s quality indicators and associated risk adjusters are those developed by interRAI for home care and long-term care homes (Hirdes et al., 2004; Mor et al., 2003; Jones et al., 2010). In addition to cross-sectional views of regional and facility-level variations, the reports include longitudinal data representing historical changes in health system performance.

With the initial introduction of public reports for long-term care homes, participation in the site-specific reporting was optional. About 100 homes participated in that first phase; however, public reporting will be mandatory for all homes by 2013.

12.6 Concluding comments

Ontario’s health and long-term care systems have made important strides over the last three decades in improving the quality of care provided to older citizens. Although much more needs to be done, important innovations have occurred in many domains. The implementation of standardized health information systems that span multiple sectors holds the promise of yielding insights into the needs of vulnerable populations that were commonly overlooked. New quality improvement and public accountability initiatives mean that quality is becoming a shared commitment, with evidence and transparent reporting as its foundation. Payment systems that aim to allocate resources equitably based on the needs of healthcare service recipients rather than on the basis of historical power differences between organizations are important from both the perspective of the rights of individuals to receive equal treatment and the sustainability of the healthcare system. Finally, the recognition that healthcare must function as an integrated system rather than a collection of independent entities focused on narrowly defined clinical activities is moving from being a platitude towards an expectation.
Even though each province/territory is administratively autonomous and relatively distinct from others, there are aspects of the Ontario experience that could be useful if adopted elsewhere. Ontario’s leadership in the adoption of comprehensive assessment systems across the continuum of care and public reporting with data from those assessments are important innovations that have led to tangible improvements in accountability and quality of care. The fact that Canada’s federal structure distributes, rather than centralizes, authority for healthcare means that no single government can set the national standard in this regard. However, Canada has never been closer to a consensus on assessment standards for home care and nursing homes than it is today. It is reasonable to expect that within the next decade only Quebec will remain outside of the interRAI standard. As implementation of these instruments nears completion, increasing attention will move towards use of the data to support reporting at the provincial level; however, the publication of comparative data for eight provinces/territories (Hirdes et al., 2011) represents the most comprehensive picture to date of the nursing home sector. A similar report was released by the Health Council of Canada (2012) using RAI-HC and other data to describe home care nationally.

Tommy Douglas, the founder of Canadian Medicare, said, ‘Courage, my friends; ’tis not too late to build a better world.’ Policy makers and the general public today have more evidence available about the quality of nursing homes and home care than at any prior point. Although perfection has by no means been achieved, Ontario’s health system for the elderly has indeed progressed towards a better world.

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