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A Home Care Model

for Naturally Occurring
Retirement Communities in Ontario



**NORC
Innovation
Centre**
at  **UHN**

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About the NORC Innovation Centre at University Health Network

The NORC Innovation Centre at University Health Network is a first-of-its-kind centre dedicated to advancing a 21st-century model of integrated health and social care in naturally occurring retirement communities (NORCs). By leveraging multiple capabilities across UHN and the broader health and social sectors, the NORC Innovation Centre (NIC) seeks to provide Canadians with new options for aging in place with dignity and choice. It was born out of the efforts of UHN OpenLab, an interdisciplinary design and innovation studio dedicated to finding creative solutions at the intersection of health and society.

University Health Network (UHN) is Canada's #1 hospital and the world's #1 publicly funded hospital. With ten sites and more than 20,000 staff, UHN consists of Toronto General Hospital, Toronto Western Hospital, Toronto Rehab, Princess Margaret Cancer Centre, The Michener Institute of Education and West Park Healthcare Centre. The scope of research and complexity of cases at UHN have made it a national and international source for discovery, education and patient care. UHN is a research hospital affiliated with the University of Toronto.

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Executive Summary

Ontario's current home care system is under-funded, disjointed and not working for the many older adults who rely on it the most. Services are still mostly delivered as though all clients live in suburban homes, often requiring extensive travel from client-to-client, performing piecemeal work that is neither satisfying for them nor their clients.

Naturally occurring retirement communities (NORCs) are places not intentionally designed for older adults but, for a variety of reasons, have become home to a high concentration of them. NORCs present a significant opportunity to re-design a home care delivery model that can leverage the density to deliver better care and experiences. In Ontario, there are close to 2,000 rental apartments, condos and co-ops where at least 30 percent of their residents are older adults. Over 200,000 older Ontarians live in these NORCs, more than the population of Ontario's long-term care and retirement homes, combined. In 2022-23, personal support workers (PSWs) delivered close to 3.5 million hours of home care services in Ontario's NORCs, valued at over \$120 million.

In interview after interview, NORC residents expressed an overwhelming sense of confusion about how the home care system works and what they're eligible for, frustration with scheduling and how care is provided, and immense difficulties navigating the system's bureaucratic inner workings. Some of these challenges are a reflection of a home care sector that is underfunded in the face of rising client needs, which has limited the sector's ability to keep pace with compensation, staff training and other supports. Funding aside, our analysis also identifies significant opportunities for quality improvement. A closer examination of home care data reveals a fragmented, uncoordinated approach where over a third of NORC buildings in Ontario have four or more home care agencies coming in to serve different clients in the same building daily.

This report explores how we might make use of the natural densities of NORCs to provide home care that's client-centered, efficient, and better for workers. It proposes a NORC-based home care model with the following characteristics:

- One lead home care agency per NORC
- Dedicated PSWs with the ability to support multiple clients within the same NORC, who are able to work a full-time or part-time shift with minimal travel, and provide client visits of varying duration and frequency based on need
- Local decision-making on day-to-day care scheduling and coordination by the lead home care agency that's responsive to client needs
- Funded on a NORC population basis rather than an individual service episode basis

In this proposed model, staff would be able to see more clients per day without compromising service delivery, yielding significant productivity gains. If implemented across all NORCs in Ontario, our analysis finds that this model could provide an additional 754,976 hours of PSW services, worth \$26,756,331, annually. Given the chronic shortage of PSWs working in home care, and the rising demand for services within Ontario's rapidly aging population, a NORC-based home care model can make a positive difference not just for those living in NORCs, but also for home care workers and the health care system more broadly. Best of all, transitioning to the model would not require significant new funding; it would simply represent a different and more efficient way to organize and deliver services where natural population densities already exist.

Getting there, however, will require political will and cooperation among all home care stakeholders.

To chart the course towards such a model, this report offers the following recommendations for the multiple actors involved:

1. The Government of Ontario should adopt and promote a new home care model geared specifically for those living in NORCs
2. The Government of Ontario should establish thresholds to help identify which NORCs are best fit for the new service delivery model
3. The Government of Ontario should pilot a NORC-based home care model across an Ontario Health Team
4. The Government of Ontario should develop a population-based funding formula for home care agencies that allows for system accountability while providing flexibility to support the needs of residents of NORC buildings
5. Home care agencies responsible for serving NORCs should be enabled to develop a new staffing model that is place- and shift-based

Introduction

Ontarians aged 65 years and older currently make up 18.5 percent of the province's population (Statistics Canada, 2023). As the population ages, the demand for home care across Canada is expected to grow by 50 percent by 2031 (Gilmour, 2018; Government of Ontario, 2021; Mahmood et al., 2022; Elevate Impact Hub, 2023).

For some older adults, home care helps them age in place by providing the support they need to continue living independently at home, instead of in an institutional setting such as a hospital or long-term care home (Government of Canada, 2016).

Home care is typically categorized as short-term or long-term. Short-stay home care users may be receiving care to help them recover from a time-limited health issue or surgery. Long-stay home care users, on the other hand, tend to need care long-term as they may need more intensive services and/or equipment due to chronic issues or illnesses (Government of Canada, 2016). As people get older, they are more likely to require long-stay home care (Organisation for Economic Co-operation and Development, n.d.).

Types of home care services

Health care: One type of service involves health care professionals providing nursing care, physiotherapy, occupational therapy, speech-language therapy, social work, and support with healthy eating, medical equipment and supplies (Home and Community Care Support Services, n.d.; Government of Ontario, n.d.; Statistics Canada, 2022). Health care professionals may provide one, many, or all of these services based on each client's needs and eligibility assessment

Personal support: Another type of service involves personal support workers helping clients with their daily needs or activities of daily living. This includes support with washing, bathing, dressing

and undressing, mouth care, hair care, preventative skin care, getting in and out of bed, and getting to appointments (Home and Community Care Support Services, n.d.; Government of Ontario, n.d.; Statistics Canada, 2022).

Homemaking: Homemaking services help clients with routine household activities like house cleaning, laundry, shopping, banking, paying bills, planning menus, preparing menus, and caring for children (Government of Ontario, n.d.).

End-of-life care at home: Individuals who require end-of-life care at home may request nursing and personal care, medical supplies, tests, hospital equipment, transportation, and some hospice services (Government of Ontario, n.d.).

In Ontario, these services are organized by care coordinators from Home and Community Care Support Services (HCCSS) and delivered by home care agencies. Data analyzed by the Ontario Community Support Association suggests that there are 760,000 individuals served by agencies through home care services funded by Home and Community Care Support Services (Ontario Community Support Association, n.d.).

It's worth noting that there are other health care providers (e.g. community support services organizations) that also deliver some forms of home care, but for the purposes of this report, we focus on home care provided by home care agencies.

According to the Canadian Institute for Health Information, half of Canadians wait a few days for home care services while 1 in 10 wait about a month. In Ontario, the median wait in 2022–23 was 4 days (Canadian Institute for Health Information, 2023). This has consequences for those in need of care. Unmet home care needs have been associated with poorer health, increased use of health services, and premature admissions to retirement or long-term care homes (Gilmour, 2018).

Integrating home care delivery in a way that's coordinated, easy to access, and continuous within a place-based model not only addresses the rising demand for home care services, but can also help enable older adults to age in place while maintaining their health (Expert Group on Home & Community Care, 2015; National Institute on Ageing & NORC Innovation Centre, 2022; NE-LHIN, n.d.; Toronto Central CCAC, n.d.).

We identify naturally occurring retirement communities (NORCs) as rental apartments, condos and/or co-ops where at least 30 percent of the residents are older adults above the age of 65. While NORCs also span wider geographic areas (i.e., horizontal NORCs), for this report, we focus on high-rise buildings because the vertical co-location of older adults can enable the more efficient and effective delivery of services, and support community-building efforts that improve quality of life (Recknagel et al., 2020). This kind of density has gone relatively unrecognized, but holds great potential for reshaping the delivery of all kinds of services for older adults.

Residents living in NORCs are 50 percent more likely to use long-stay home care than residents living in non-NORC settings (Savage R, et al., 2024). The reasons for this are not fully understood at this time. However, while NORCs are located in all kinds of neighbourhoods, overall, NORC residents generally have lower incomes and higher health needs compared to older adults living in other settings (Savage R, et al., 2024).

This makes NORCs a good place to explore opportunities to improve home care delivery. In particular, how might we take advantage of the natural densities of NORCs to provide home care that's client-centered, efficient, and better for workers?

This document describes the opportunity to tap into the natural density of NORCs to make home care more integrated, client-centered and less-fragmented within NORC settings. It has implications for all stakeholders of Ontario's home care system, including the Ontario Ministry of Health, Ontario Health, Ontario Home and Community Care Support Services and soon to be Ontario Health atHome, Ontario Health Teams, home care agencies, as well as older adults living in NORCs and the people who care for them.

Naturally occurring retirement communities

Naturally occurring retirement communities (NORCs) are communities that naturally come to house a high density of older adults over time (Hunt & Gunter-Hunt, 1986). NORCs may include rental apartments, condos and co-ops, but do not include communities that were purpose-built to provide care for older adults such as retirement homes, assisted living facilities or long-term care homes.

The NORC Innovation Centre defines NORCs as buildings where at least 30 percent of residents are 65 years of age and older, with a minimum of 50 older people per building. Based on this definition, there are 1,941 NORCs housing a total of 217,000 older adults in Ontario (National Institute on Ageing & NORC Innovation Centre, 2022). There are more older adults living in NORCs in Ontario than the number of people living in LTC homes and retirement homes combined (National Institute on Ageing & NORC Innovation Centre, 2022).

Methodology

We interviewed NORC residents, drew on data from Home and Community Care Support services and consulted with home care stakeholders to inform a NORC-based home care model.

To learn about the home care experiences of NORC residents, we conducted one-on-one key informant interviews with 15 NORC-residing older adults who are home care users and/or their caregivers. We also spoke to PSWs and management staff from home care agencies. Individual experiences have been anonymized and pseudonyms are used.

We also requested data from Home and Community Care Support Services (a provincial agency responsible for coordinating home and community care for Ontarians) to understand how home care services are delivered within NORC settings. This data, obtained from the Client Health and Related Information System (CHRIS), provided aggregate counts of the number of unique patients, average number of active patients, number of services provided and number of health service providers by home care service type for all NORC buildings in Ontario from April 1, 2022, to March 31, 2023.

Modeling of home care costs and potential productivity gain associated with moving to a NORC-based approach to home care delivery was based on evaluation results from a pilot project by Closing the Gap (a home care agency). The pilot project's Neighbourhood Model shares several key characteristics with the NORC-based model proposed in this report, particularly dedicated PSWs who serve multiple clients within a tight geography area, who are able to work a full-time or part-time shift with minimal travel and provide client visits of varying duration based on need. While Closing the Gap reported a productivity improvement of 44 percent compared to the usual home care model, this report uses a more modest estimate of

22 percent in its productivity assumptions—half of the amount reported by the pilot.

In June 2023, we held a by-invitation-only meeting to review and discuss early findings with a cross-section of home care stakeholders, including representatives from the Government of Ontario, the home care industry, home care clients, and health system experts. The stakeholders were also facilitated through a generative exercise to design a new home care model that would make use of the natural densities of NORCs to provide home care that's client-centered, efficient, and better for workers.

Finally, and in consideration of all of the above, the co-authors of this report crafted a series of recommendations and drafted an early version of this document, which was shared with several expert reviewers for input. These reviewers are acknowledged on page 5.

Current State of Home Care in NORCs

Despite all the changes that have occurred over many years to the provision of home care in Ontario, the way home care is delivered has largely remained the same – a government agency is responsible for determining clients’ eligibility for care and for procuring services from home care agencies. Home care agencies, in turn, are responsible for delivering the contracted services to a particular client. Within a NORC where there are multiple home care clients, there might be multiple agencies or multiple home care staff from the same agency going in and out of the same building, serving different clients, and sometimes the same client.

PSW services, such as providing help with washing, bathing, and dressing, make up the highest volume of home care activity. Among all NORCs in Ontario, there were a total of 3.4 million hours of service delivered by PSWs in 2022 – 23 (HCCSS, 2023).

Table 1: Total number of hours of long-stay home care services provided in Ontario NORCs, April 1, 2022 – March 31, 2023

Home care services	Total Hours
PSW hours	3,431,707
Nursing visits	442,101
Therapy/other visits	109,305

Our analysis shows that in Ontario, approximately 85 percent of NORCs are receiving PSW services from two or more home care agencies (HCCSS, 2023). Furthermore, approximately 35 percent of NORCs have four or more agencies coming in to serve clients living in the same building, and some have as many as 6, 7 or more agencies (HCCSS, 2023).

Table 2: Number of home care agencies serving a NORC building, April 1, 2022 – March 31, 2023

Home Care Agencies	# NORC Buildings	Percent
0	30	1.6%
1	260	13.4%
2	508	26.3%
3	467	24.2%
4	386	20.0%
5	194	10.0%
6	61	3.2%
7 or more	28	1.5%

The data presented in Table 2 points to an opportunity to streamline home care services within NORC buildings where multiple home care agencies are going into each building. Furthermore, these numbers do not capture all Ontarians who, despite needing care, aren’t able to receive the care they need due to long wait times for assessments and/or care delivery, strict eligibility criteria, and so forth. With a streamlined NORC-based model, we could likely free up capacity to meet the increasing demand for care. We’ll review what a streamlined NORC-based model could look like in a later section of this report.

NORC Residents' Home Care Challenges

To understand the current experience with home care, we visited and spoke with 15 older adults and/or their caregivers. These NORC-residing older adults who are home care users identified several challenges with the current system, including:

- Confusion around eligibility and what services are publicly funded
- Dissatisfaction with scheduling and the lack of consistency in terms of who is coming into the home from week to week, and
- Frustration with having to navigate a fragmented system where multiple agencies serving the same client are not coordinating with one another

The challenges summarized below outline the experiences older adults too often face with the home care system.

Accessing Home Care: confusion with how home care works and what one is eligible for

Many home care users we spoke with accessed home care through a referral via the hospital that treated them, to aid their recovery from injury or illness. Some of these older adults started off with a referral to help them with short-term needs, but ended up being long-stay clients once their needs were identified as longer-term. In other cases, physicians noticed a trend in long-stay needs following an injury or illness.

In instances where older adults were accessing care through other means (through a family doctor or self-referral), we heard that having knowledge of the home care system made accessing home care easier – they knew who to address questions to and how to navigate the system to get the care they needed as soon as they could. In the same vein, having a loved one, family doctor or health care professional advocate for them was seen as critical.

Will's experience with multiple providers

We spoke to an older adult named *Will* to learn about his experiences as a home care user since 1996. At one time, *Will* was receiving homemaking services from one home care agency, personal support from another agency, and nursing from a third agency. *Will* had to coordinate appointments between three different providers to avoid any overlap since the agencies themselves didn't know when others were coming in to provide care.

In addition to three different home care agencies coming in, there were different home care staff coming in for some of these visits. *Will* found that the staff weren't always sure of what they were supposed to do, and it sometimes felt like he was "taking care of the worker" by having to tell them what their tasks were and if there were any changes to his overall health. For example, when he had a wound and wasn't allowed to shower, the PSW that helped him bathe wasn't aware of his wound or the changes to his bathing routine. *Will* felt like he was responsible for communicating these changes to ensure his overall health needs were maintained. He wished there was a better way of communicating these changes and coordinating schedules without feeling the burden of responsibility.

There was a lot of uncertainty around what services were publicly funded, and in what conditions home care users would be eligible for certain services. For example, in some of our interviews, older adults wished housekeeping and meal preparation was

provided as part of publicly-funded care, even though it is, according to the Government of Ontario's website. These older adults were just deemed ineligible for these services by their HCCSS coordinator. Availability of and eligibility for a home care service are two different things, and this wasn't clear to some of the older adults we spoke with.

In other instances, older adults reported a need for more services beyond what was offered. Some PSWs helped them with tasks outside of their assessed care "out of the goodness of their heart," but there was a general consensus among those we spoke to that there was a need for more clarity around what services are publicly funded and how eligibility for services are assessed and determined.

Care Coordination: frustration with scheduling and how care is provided

Once a client is assessed and deemed eligible for care by their care coordinator from HCCSS, home care agencies are responsible for providing care to that particular client. Home care agencies sometimes conduct their own, second assessment before providing care. We heard from multiple older adults that this was a confusing and overwhelming process. Julie, an older adult who is a caregiver for her husband, said that her husband had to go through four different assessments: one from HCCSS, another from his home care agency, and then another from his nurse and occupational therapist. This was an added layer of stress for Julie, especially since her husband was recently discharged from the hospital, and she was caring for him.

"When a client is being referred for home care from the hospital, the hospital referral should be enough to dictate care needs."

—Julie, NORC resident and caregiver

In addition to multiple assessments, home care agencies responsible for providing care to eligible

clients schedule staff using their own protocols. Depending on the type of referral made to home care agencies (time-specific or non-time specific), agencies either inform clients of their schedule and what services they will be receiving, or work with the client to understand their preferences and see what is possible based on availability. It's worth noting that staffing challenges can make it difficult for home care agencies to accommodate scheduling preferences.

However, we heard from multiple older adults through our one-on-one interviews that scheduling of home care visits often did not take their preferences into consideration. We also heard that home care staff often did not arrive during their scheduled time. In some cases, older adults felt like staff rushed their work to leave for their next appointment, instead of staying for the entirety of their scheduled visit. The increasing demand for home care has continued to exacerbate these concerns as home care agencies grapple with ongoing staffing challenges to balance client preferences with staffing availability.

Most community PSWs travel between appointments – with some of them quite far from one another. Not only is this travel time poorly compensated or not at all, but when appointments are scheduled back-to-back, it can put a lot of pressure on PSWs and care can feel rushed for clients. This was stressful for some of the older adults we spoke to.

"The time stress on workers means they have to rush and seniors feel rushed and aren't able to ask for anything beyond the bare minimum. The stress creates a very bad atmosphere and lots of tension between workers and seniors."

—Hannah, NORC resident and home care client

These challenges are exacerbated when older adults receive different types of services from different home care agencies. From a coordination perspective, they end up feeling responsible for

coordinating all the appointments in a way to avoid overlap between the different services – when the onus should be on a coordinating body, not the clients themselves.

“Juggling all of these appointments is a full-time job. I feel like an air traffic controller having to coordinate all my appointments, bloodwork and scans”

—Frank, NORC resident and home care client

Service Delivery: difficulty navigating a fragmented system

Because care is assessed and coordinated by a government agency and delivered by a home care agency, we heard from multiple older adults that they weren't sure who to contact when they have questions – do they contact HCCSS or the agency providing the service? In some cases, they weren't sure if home care agencies or HCCSS were the ones providing their care.

Some older adults also felt that the service structure between HCCSS and home care agencies meant that the people conducting care assessments (HCCSS coordinators) and the people delivering the care (home care staff) weren't as connected as they should be. Older adults' needs for services constantly change, and they can change rapidly depending on their health status and personal circumstances. Providers who are in direct contact with older adults often have a better grasp of their changing health needs. However, since care is predetermined and split by service type in set durations, there is little flexibility from home care staff when older adults have needs outside of their specific predetermined tasks.

We also heard a preference to have the same home care staff come in for their appointments, whenever possible. In cases where there was no consistent person coming in, older adults often had to re-explain what they needed help with every time a new staff

member showed up. Some new staff also refused to help with certain types of services as they said it wasn't a part of their job description – even though the older adult received this type of support from other staff within the same agency. We heard many times that there's a need for more consistent quality of care, which includes staff being familiar with the tasks they can and can't help with, and the services they're responsible for providing prior to every appointment. This can contribute to more personalized care and improved trust between staff and home care users.

“Having to explain what I need help with and how I'd like them to help me every time someone new comes in feels demeaning.”

—Hannah, NORC resident and home care client

The experiences described in this section are the result of a combination of different factors. For one, funding structures where home care agencies and workers are compensated on a fee-for-service basis can result in care that feels transactional instead of client-centred. Workforce challenges, including difficulty recruiting and retaining staff, mean that there aren't enough home care staff available to meet the rapidly growing demand for home care.

Towards a Better Home Care Model in NORCs

With 1,941 NORC buildings home to 217,000 older adults, Ontario is well-positioned to make use of the natural densities of NORCs to provide home care that's client-centered, efficient, and better for workers.

A foundational first step in doing so is to assign one lead home care agency for each NORC. In cases of smaller NORC buildings where there might not be sufficient numbers of home care clients, several NORC buildings in close proximity could be grouped together under the responsibility of a single, lead home care agency.

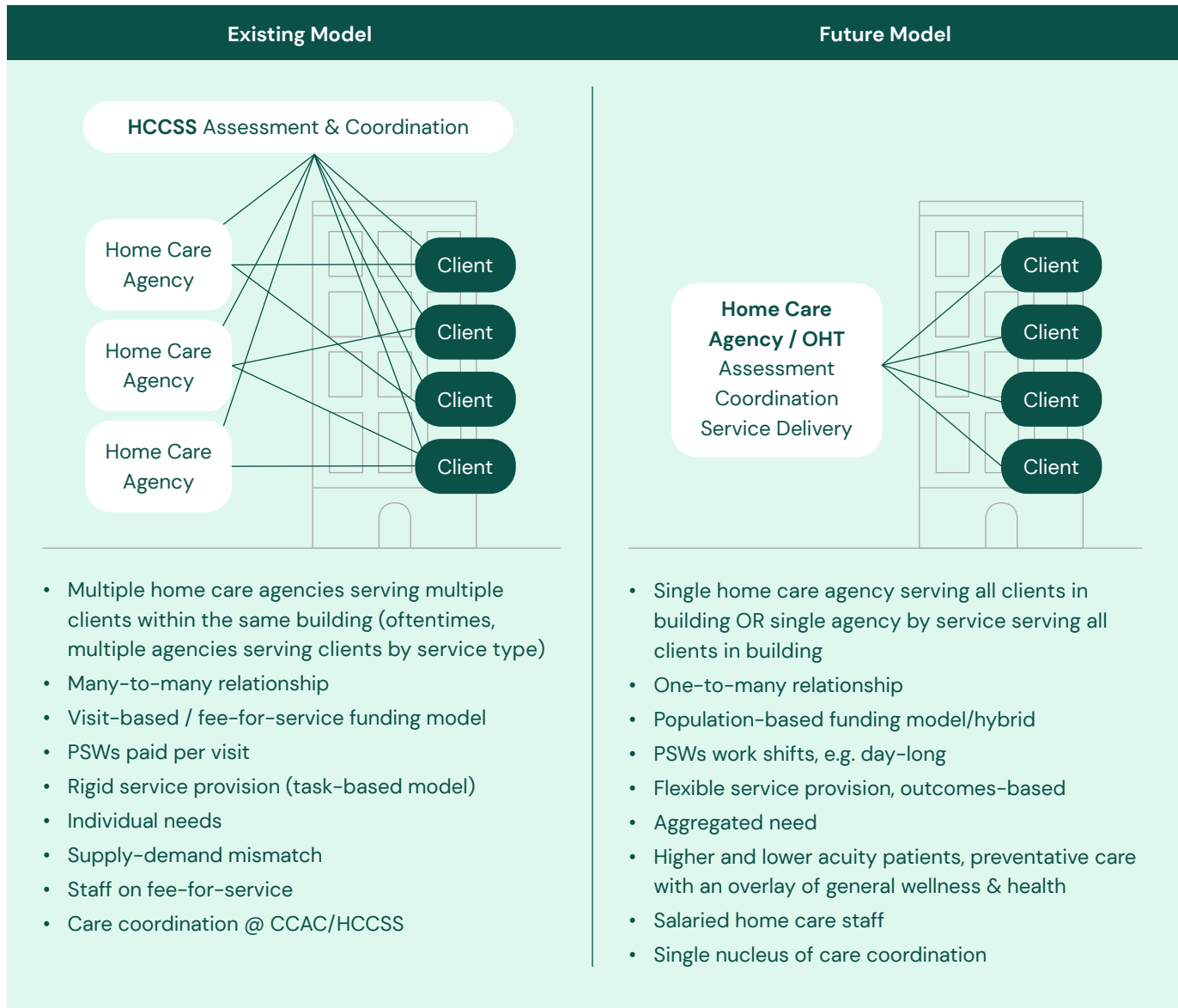
In cases where a lead home care agency does not provide all types of home care services, the lead agency may subcontract with other agencies for the missing services (e.g. nursing or physiotherapy, etc.) while still retaining overall responsibility.

A single-responsible agency can solve some of the issues identified earlier, such as the lack of coordination and frustration clients often feel when trying to schedule and communicate with multiple parties. Care coordination under this model could be done much more efficiently, directly through the lead agency. With clear accountability and a funding model that allows for flexibility, assessing any new home care needs, scheduling home care staff and coordinating each client's care could all be done closer to home, at the level of the NORC. This means that care decisions are being made by someone who knows each client and their needs, and communication between home care agencies and users are streamlined, which can help develop trust and more consistent service. A lead agency also allows for home care to be more easily integrated with the rest of the local health care system, say through Ontario Health Teams

(OHTs are groups of organizations from across health care and other sectors responsible for care in their local communities).

Moving to such a model does not require any major overhaul of the regulatory frameworks governing home care. Regulations under the Connecting Care Act, 2019 already permit health service providers (which includes home care agencies) and Ontario Health Teams to make care coordination decisions indirectly (Ministry of Health, 2022). The recently introduced Convenient Care at Home Act, 2023, which would eventually transition the responsibility for home care to OHTs, is highly complementary as it intends to embed care coordinators directly into the community through OHTs.

Home Care Delivery Models in NORCs

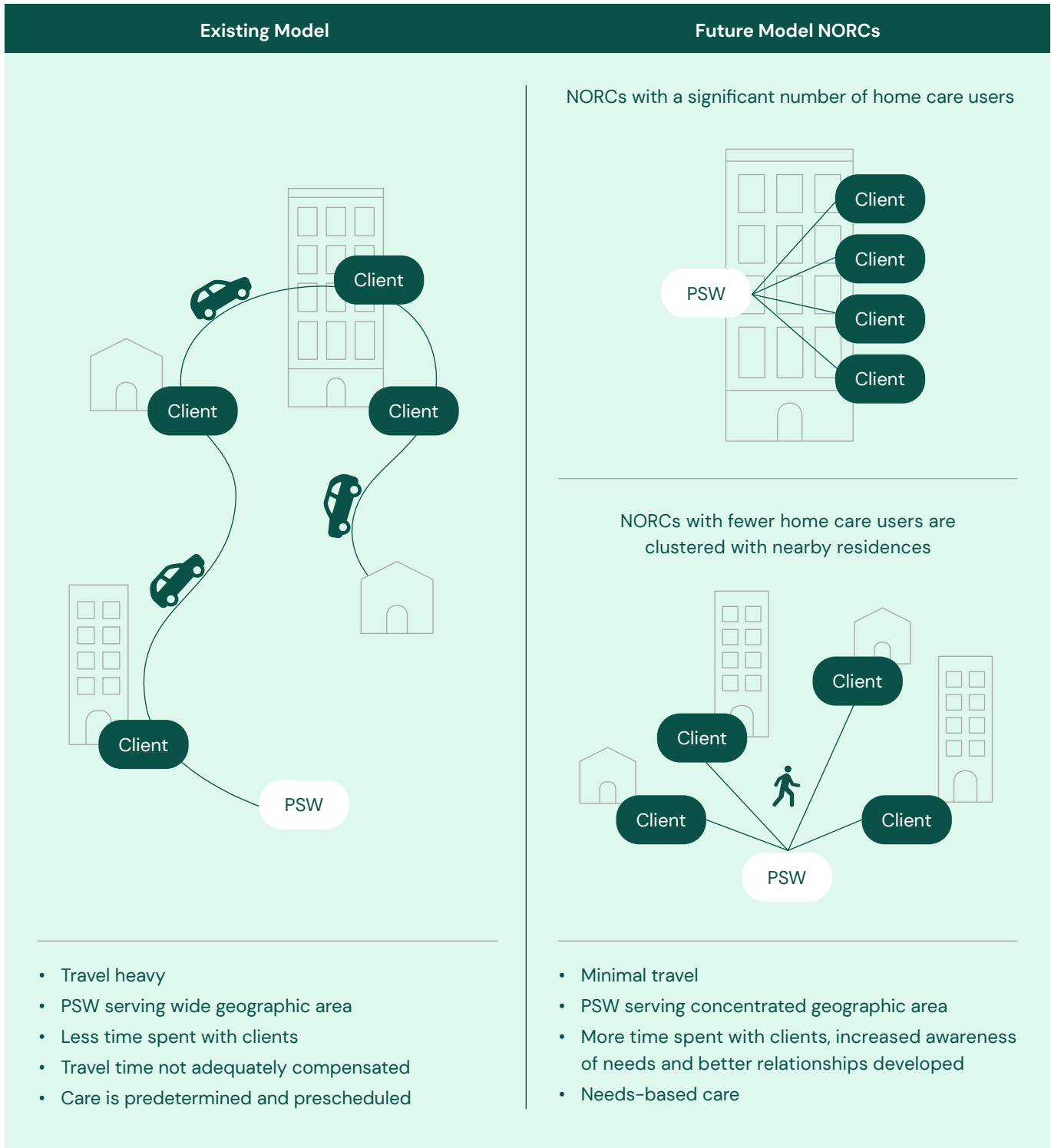


However, for the model to be truly client-centred, the funding model also needs to change. Under the existing model, a government agency (HCCSS) funds home care agencies on a fee-for-service basis and PSWs are typically paid by their agency in the same way; usually on an hourly basis. However, sometimes a client might not need all of their allocated time and at other times, they might need a little more. Moving to a staffing model where PSWs have a mix of clients of different levels within a tight geography allows for the kind of scheduling flexibility needed to maximize the time they spend doing productive client work.

As John, a NORC resident in midtown Toronto said: "I need someone 6 times a day for 20 minutes not once a day for 2 hours."

In NORCs with a significant population of home care clients, this staffing model makes intuitive sense. It also allows for the transition away from piecemeal work towards a salaried staffing model with minimal travel time, which helps improve PSW working conditions and, from a workforce recruitment and retention perspective, makes working in home care more attractive.

Home Care Staffing Models in NORCs



Across Ontario, attempts at moving home care delivery to a clustered model have been made in the past. However, these have been isolated, and

sometimes fleeting efforts, that have yet to gain widespread adoption as evidenced by the data shown in the previous section of this report.

Case Study: Closing the Gap Healthcare & Waterloo Wellington LHIN's Neighbourhood Model

The Pilot

In response to ongoing staffing capacity issues with personal support workers (PSWs), Closing the Gap Healthcare (a home care agency) and Waterloo Wellington LHIN launched a pilot project called the "Neighbourhood Model" in January 2018 (Closing the Gap Healthcare, 2019). The model involved hiring full-time salaried PSWs who were responsible for providing home care to clients within a tight, two-kilometre radius area in Waterloo.

Full-time, salaried PSWs were hired with fixed schedules to care for clients living within the neighbourhood every day based on their needs. This steered away from the current task-based model, where PSWs are paid on an hourly or per-visit basis with a significant amount of travel.

Staff were required to work as a team and integrate themselves between the home care agency and a single care coordinator from WW-LHIN. Closing the Gap served as the lead home care agency and was responsible for all the care provided within the region.

The WW-LHIN care coordinators and PSW supervisor were responsible for personally communicating with clients to develop schedules. Because the neighbourhood was dense and housed a high proportion of clients in need of support, Closing the Gap was able to provide consistent full-time and part-time work for PSWs. Any buildings within their catchment that had the volume to support a dedicated team member, had one. They adopted a shared care billing model based on the actual time used to provide care, instead of the standard one-hour funding blocks that were typically used.

Results

An evaluation of the pilot by Closing the Gap Healthcare found that compared to the usual model of home care, the Neighbourhood Model demonstrated the following outcomes:

- Improved client satisfaction (92 percent compared to 82 percent for usual home care)
- Improved continuity of care (greater consistency of PSWs serving the same client)
- Improved productivity (1–2 percent of PSW time spent traveling compared to 8–10 percent under the usual provision of home care; average length of visits of 30–40 minutes compared to 60–70 minutes under the usual provision of home care; and overall, 44% more client visits took place than under the usual provision of home care)

Learnings

While the overall results were overwhelmingly positive, there were challenges. In the initial implementation, there was little time for recovery for PSWs between clients. Due to the increasing number of clients they visited in a day, this might lead to PSW burnout over the long-term. One suggestion from staff was to incorporate a small amount of buffer time between clients so that PSWs don't feel so rushed. While this would eat into some of the productivity gains reported, such tweaks to the model were seen as important to ensuring staff satisfaction and program sustainability. The pilot also identified the need to hire part-time PSWs to supplement the full-time staff to better manage the peak demand for services, which tend to occur early and later in the day.

The pilot ended in 2019. The Neighbourhood Model is still operating in the Waterloo Wellington region and will soon be expanded into the Mount Forest region (Personal communication, 2024).

A NORC-based home care model—a lead agency delivering PSW services where staff work a day-long shift with minimal travel—is not only more accessible and easier to navigate for home care users, but it also gives provider organizations more autonomy over scheduling and the ability to adjust services to meet residents’ constantly changing needs. Moreover, with clients being co-located in the same building, it opens possibilities for a variety of programs that could be efficiently delivered in groups (like exercise classes or health education talks) that contribute to health and wellness at a building level. This can potentially delay or reduce the need for home care or long-term care and improve overall quality of life.

Cost Effectiveness of NORC-based Home Care Model

The Neighbourhood Model piloted by Closing the Gap in Waterloo, although it served a wider catchment area than a specific NORC building, shares many of the characteristics of the NORC-based home care model described above. This includes employing PSWs who work a day-long shift serving a tight geography with minimal travel, and a care model that allows them to serve more clients per day through shorter visits based on client needs. Because staff can see more clients per day without compromising service delivery, it is anticipated that moving to a NORC-based home care model would yield significant productivity gains. Evaluation of the Waterloo pilot determined this productivity gain to be 44 percent—defined as the increase in the number of client visits with the same PSW workforce.

Even if moving to a NORC-based home care model were able to produce just half of the productivity gains reported in the Waterloo pilot (22 percent), that would translate into an added 754,976 hours or \$26,756,331 in PSW services for the home care system, annually. It means that more clients can be served with the same workforce compared to the traditional, fee-for-service model.

Given the chronic shortage of PSWs working in home care, and the rising demand for services by Ontario’s aging population, a NORC-based home care model could make a positive difference not just for those living in NORCs, but also for the home care and health care systems more broadly. Best of all, transitioning to the model does not require significant new funding; it’s simply a different and more efficient way to organize and deliver services where natural population densities already exist.

Table 3: Estimated Productivity Gains From Adopting a NORC-based Home Care Model in Ontario, April 1, 2022 – March 31, 2023

	Hours of PSW Services Delivered in NORCs in Ontario ¹	PSW Cost ²
Existing Model	3,431,707	\$121,619,696
Productivity Estimate	22%	22%
NORC-Based Home Care Model	4,186,683	\$148,376,029
Productivity Gain	754,976	\$26,756,331

1 PSW hours are based on volume of services delivered in Ontario NORCs for the period April 1, 2022 – March 31, 2023.

2 PSW cost is based on a harmonized hourly billing rate of \$35.44. This hourly rate was used by Closing the Gap in the evaluation of the Waterloo pilot in 2019, and is likely higher today.

Recommendations for Improving Home Care in NORCs

The recognition of NORCs as a valuable construct for health services innovation came during the COVID-19 pandemic when mobile vaccination teams were able to administer vaccines on-site to thousands of older adults, taking advantage of their natural co-location in these high-density settings (Huynh et al., 2021). It is not difficult to imagine how NORCs could stimulate similar interventions across a wide range of health and social services where such density remains an untapped resource. The delivery of home care services, in particular, is ripe for change for all the reasons described in the preceding sections. However, unlike the COVID-19 pandemic, which was unprecedented, moving to a NORC-based approach to home care is complicated by legacy funding structures, historical market share considerations, fragmented responsibilities, and chronic workforce challenges that makes it even more difficult to attract and retain good, caring staff. Getting there requires the simultaneous collaboration among multiple stakeholders, in particular: Ministry of Health, Ontario Health, Ontario Home and Community Support Services (HCCSS) and soon to be Ontario Health atHome, Ontario Health Teams, and home care agencies. For simplicity, due to current transitions in Ontario's home care sector and changing responsibilities among the key actors, the term "Government of Ontario" is used here to broadly refer to the Ministry of Health and/or the various government agencies involved in home care. The following recommendations are focused exclusively on the question of how to better deliver home care in NORCs rather than how to fix home care generally.

Recommendation 1

The Government of Ontario should adopt and promote a new home care model geared specifically for those living in NORCs

This NORC-based home care model should have the following characteristics:

- One lead home care agency per NORC; in cases where a lead home care agency does not provide all types of home care services, the lead agency may subcontract with other agencies for the missing services (e.g. nursing or physiotherapy, etc.) while still retaining overall responsibility
- Dedicated PSWs who serve multiple clients within the same NORC, who are able to work a full-time or part-time shift with minimal travel, and provide client visits of varying duration and frequency based on need
- Local decision-making on day-to-day care scheduling and coordination by the lead home care agency that's responsive to client needs, without the need to involve third parties in the process (e.g. central, provincial coordination)
- Funded on a NORC population basis rather than an individual service episode basis (which would include care coordination support), particularly for NORCs with a sufficiently large number of eligible home care clients

Recommendation 2

The Government of Ontario should establish thresholds to help identify which NORCs are best fit for the new service delivery model

Every NORC building is unique and will have a different number of long-stay home care users. While it may make sense to implement a NORC-based home care model within some buildings, that may not always be the case. For example, in NORC buildings where there are just a few long-stay home care users, it may not make sense to allocate resources

(financial and staffing) to assign one home care agency per building.

The following parameters should be considered when establishing the thresholds:

- The number of long-stay home care users in a building
- The total number of hours care is being provided in a building
- The number of services being provided
- The number of agencies providing services at a building level

In addition, home care utilization data was only readily available for services provided by home care agencies. The ability to track and consolidate this data with service delivery from community support service agencies would help to better focus service delivery.

Recommendation 3

The Government of Ontario should pilot a NORC-based home care model across an Ontario Health Team

In implementing the new model, many operational details will need to be worked out. The most challenging might be an approach to designating one lead home care agency per NORC that does not adversely impact the market share of any agency or disrupt client service.

Seven OHT-led leading projects were recently launched to model innovations in integrated home care services within OHTs. These projects aim to test and evaluate OHT-led home care models that improve the home care experience while building OHT capacity for home care planning, delivery and integration. These OHTs could be strong partners for piloting a NORC-based home care model, as efforts are already being made to integrate home care within these regions, or there could be an opportunity to test out complementary approaches to strengthen existing plans and learnings.

Recommendation 4

The Government of Ontario should develop a population-based funding formula for home care agencies that allows for system accountability while providing flexibility to support the needs of residents of NORC buildings

For this model to work and to ensure that clients are getting the care they actually need, the Government of Ontario should develop a population-based funding approach for home care agencies who are responsible for providing care in a NORC building.

This would involve developing a funding formula that accounts for the number of home care users and their needs by region, and providing home care agencies a fixed amount of funding on a recurring basis. This will enable more flexible service provision as older adults will get the care they need for that day, at times that works best for them. There should be mechanisms in place to adjust for changes in client volume and acuity levels.

Recommendation 5

Home care agencies responsible for serving NORCs should be enabled to develop a new staffing model that is place- and shift-based

Shifting to a home care model where workers serve multiple clients in the same NORC will also require home care agencies to adapt their staffing model accordingly. Once a population-based funding model has been implemented, home care agencies should adopt a staffing model that is place-based, shift-based, and salary-based – while being mindful of employment conditions agencies may currently have in place. This can be done by scheduling a combination of full-time and part-time staff to work at a building or neighbourhood level. This will reduce travel time and make the workday more predictable for home care workers. It will also ensure that clients get more consistent care, from staff who are regulars in the building, who are also part of the NORC community.

Conclusion

With the demand for home care expected to grow by 50 percent by 2031 across Canada, there's an urgent need to make use of the natural densities of NORCs to improve access and quality of care.

The Government of Ontario has prioritized home care modernization, acknowledging that the current system is disjointed and not working for many older adults. This modernization includes Ontario Health Teams taking responsibility for connecting people to home care services starting in 2025, as well as the establishment of a new organization, Ontario Health atHome, responsible for "coordinating all home care services across the province through Ontario Health Teams."

A NORC-based home care approach is highly complementary to the modernization agenda. In fact, with increasing numbers of older adults residing in NORCs over time, it makes sense to consider NORCs as a distinct home care client base where the modernization agenda could be taken a step further—to take advantage of the natural densities to provide home care that's client-centered, efficient, and better for workers.

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