Final Testimony, June 15 Social Policy Hearing

Good morning Committee members, and thank you for the invitation to share our perspective on Bill 175. My name is Cathy Barrick, Chief Executive Officer of the Alzheimer Society of Ontario. Joining me is Kyle Fitzgerald, our Manager of Public Policy and Government Relations.

Across Ontario, 29 local Alzheimer Societies serve over 160,000 clients each year, including both people living with dementia and their care partners. In every community in the province, the Alzheimer Society is an integrated part of the health-care system. We offer system navigation, adult day programs, counselling, social recreation, caregiver education, and in-home respite, among many other support programs. We are considered a provider of community support services under the *Home Care and Community Services Act*, and we would be considered a provider of "community care services" should Bill 175 become law.

The Alzheimer Society is supportive of the intent of this Bill. Bringing home and community care providers under the same legislative framework of other health-service providers will help advance the goals of the Ontario Health Team framework, which the Alzheimer Society has embraced: all 29 local Alzheimer Societies are involved with at least one OHT group. We applaud any progress towards a more patient-centred health-care system.

We would like to draw your attention to four details of Bill 175: the removal of maximum service hours, continued co-payment requirements, broadening eligible service locations, and expanding home and community care to include all nonprofit health-service providers.

We welcome the removal of service maximums under Bill 175. This is a sign of trust in the sector, and removes a constraint not placed on primary or acute care providers. We flag that this move creates the risk for already limited resources to skew towards higher-needs clients, further distancing those living with dementia from vital community support

services. Removing service maximums alone will not mean that every home and community care client gets a level of service tailored to meet their unique situation. This is only one step towards that goal: community support providers are already lean, efficient entities, and allocating more resources to some clients will mean giving less to others, unless additional investments are made in the sector.

Secondly, the proposed Bill would maintain client co-payments. The Alzheimer Society makes every effort to accommodate clients regardless of their financial situation. In cases where clients cannot afford their co-payment, we try to absorb it—meaning that co-payments are a downloaded cost, from the government onto providers. This also creates a de facto service maximum: lower-income clients get access to services their provider can afford to cover, which does not always meet their needs and can change from year to year. This is especially true for higher-cost services, such as in-home respite. And even in cases where we offer to cover a client's co-pay, many decline this help out of a sense of pride.

Thirdly, we are pleased to see service locations expanded to include public hospitals, and would encourage continued collaboration between hospitals and home and community care providers as this is rolled out. Offering community care in hospitals allows for continuity in areas like meal support and personal care, lowering the risk of falls or responsive behaviour while in hospital. Admission to hospital is a stressful experience, especially for someone living with dementia, and maintaining some familiarity and routines from their usual day-to-day life helps remove some of this stress.

We would suggest further expanding service locations to include long-term care. A transition to long-term care is often an upsetting experience, and for individuals living with dementia a change in environment or routine can lead to responsive behaviours. Allowing home and community care workers to continue supporting clients for a short period as the client adjusts to their new environment would be a source of reassurance to the individual and their care partners. This would have to be limited to a well-defined time period, so home and community care resources are not diverted permanently into

long-term care homes. Done right, this would make this step in someone's life a less distressing experience, and reduce the risk of a trip to the emergency room—a common occurrence in the weeks following a transition to long-term care.

Our final point concerns the expansion of funding eligibility for home and community care services to include all not-for-profit health-service providers. While we welcome collaborative partners, we caution that this could lead to duplication and waste, as new providers begin to offer community services without the benefit of decades of experience and expertise. This move could also disrupt longstanding client relationships. Funding and procurement guidelines under this new framework should be evidence-based, taking experience into account to ensure continued value and quality of care.

The Alzheimer Society will be submitting a written brief with a summary of our comments. Once again, thank you for considering our feedback, and we are happy to answer any questions you may have.