OCSA
Ontario Community Support Association

September 2019

Anchored in Home and Community

OCSA's vision for a redesigned home and community care sector within Ontario Health Teams

Key Messages for Appendix A of the Ontario Health Team Application

Enabling a Successful Transformation

The Appendix A of the Full Application form for Ontario Health Teams (OHTs) asks partners to provide a long-term vision for the modernization of the delivery of home and community care system. This document articulates Ontario Community Supports Association's (OCSA) vision. It also identifies several promising practices from across the province that will provide paths to improving care coordination, system navigation, developing clinical treatment/care plans and delivering services to clients.

This resource is one of many developed by OCSA to support members succeed in the current health system transformation. As more information becomes available and the transformation advances, this document will be refreshed as need. For more information and to ensure this is the most up to date version, members are encouraged to visit www.ocsa.on.ca.

A Strategic Partnership to Deliver a Roadmap

OCSA, the Ontario Hospital Association and Home Care Ontario are working together on the design and development of an actionable framework for home and community care in OHTs. This work will look at the key functions in the sector including care coordination, procurement, contract management, service delivery, administrative functions and technology. The framework will available in December 2019.

104 - 970 Lawrence Ave. W., Toronto ON M6A 3B6
T. (416) 256.3010 F. (416) 256.3021
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HOME & COMMUNITY SUPPORT
United in our commitment to care

The New Reality of Home and Community Care

Home and community care services benefit all members of our community and providers across the entire health system. These services provide assistance to a full range of clients, including children, people of all ages with disabilities, acquired brain injuries or chronic illness, seniors and their family caregivers.

These cost-effective services improve quality of life and benefit the health system by preventing unnecessary hospitalizations, emergency room visits and premature institutionalization. As they encompass health promotion, preventative services and re-enablement services, they don't stop at meeting a client's current needs - they defend against decline and more serious needs in the future, when funded adequately. They are also offered throughout a client's journey across the care continuum.

The home and community care sector has always supported the acute care needs of a client population. However, over the past decade there has been a shift in the proportion of high acuity clients being cared for in the community. By embracing a philosophy of independent living, programs such as attendant care services and outreach services offer people with physical disabilities the opportunity to live with dignity in their chosen community and to participate in every aspect of their life. Ventilator dependent clients can thrive in their own homes living in the community with appropriate services. Clients, who a few years who would been placed in long-term care, are now cared for at home with nursing, professional and personal supports services or in assisted living services hub and spoke models.

The sector is an affordable alternative to hospital and long-term care that can free up much-needed hospital and long-term care capacity in the short term, with lasting future impacts.

Our vision

OCSA's vision is built on the quadruple aims of improved patient experience, better population health outcomes, improved care team wellbeing and achieving sustainable and reduced costs. These aims can only be achieved by addressing social determinants of health through an integrated system of health and social care.

A seamless health and social care system will enable Ontarians to live independently in their homes and community for as long as they can. To achieve a system for Ontarians that is truly seamless – where they can access services when and where they need them and move through the system with ease - all sectors and service providers must work together in a truly cohesive and integrated way.

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OHTs will be able to achieve this by delivering a set of home care, community support and independent living services that safely enable clients to live at home and in their community for as long as possible.

In our vision, care is determined collaboratively with the client, their team of providers and anchored with the primary care service provider. Clients will have easier access to hospitals and long-term care, since these services will be seamlessly connected to a broader, high quality, integrated and sustainable health and social care system.

The ideal future state includes appropriately resourced and financed access to a full range of home and community services which support health promotion, preventative services and re-enablement. By properly leveraging all these services, the home and community care sector can be efficient at keeping people healthy in the community and helping them return home sooner after a hospital stay.

Critical to the success of home and community care is the important role that caregivers play. Seventy percent of the care in home care is provided by caregivers. Caregiver programs play an essential role in supporting home and community care programs and the broader health system. Ensuring caregivers are properly supported is central to our vision of successful OHTs. Innovative programs in Thunder Bay offer respite in home settings for caregivers who need a bit of longer break in order to continue to be able to care for their loved ones.

In addition to being able to leverage the sector's services, in our vision technology platforms are utilized to support and enhance service delivery. For this to happen all members of an OHT must abide by the principle that their digital tools and platforms are either standardized or meet the highest standards for interoperability.

The province should ensure that the framework for service delivery is flexible enough to meet local needs and enable innovation, but consistent enough to ensure access to predictable high-quality services across the province.

A final key part of our vision is that Ontario Health Teams will be community governed. This means they will be governed by a structure that meet the needs of and is accountable to their local communities and partners.

Promising Practices for Success

Streamline care coordination and assessments

The current system of care coordination and care need assessments results in the duplication of assessments that add no value to the care provided and reduces client satisfaction. The care coordination process needs to be redrawn to minimize bureaucracy and improve patient and family experience by utilizing a standardized intake screener and assessment tool, simplifying navigation and communication during transitions between providers.

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Because there is no common electronic medical record, providers in the circle of care, cannot share information. As a result, patients feel their needs are not being met as they are forced to repeat their health and personal information multiple times with different providers.

Community support service providers have developed innovative ways to streamline care coordination and system navigation. Promising practices include the shared intake, shared client record and coordination of care, which has been developed by 13 Community Support Service agencies in southwestern Ontario as well as the One Client One Plan developed in northeastern Ontario, which streamlined information sharing across providers by expanding and spreading the use of current technology and assessment tools across home care and community support services.

Systems navigation should ensure seamless transitions

As is noted in the U.K.'s National Health Service's competency framework for system navigation, "the core function of navigation is the elimination of barriers to timely care across all segments of the healthcare continuum." [1] This health system transformation gives providers an opportunity to redesign the system to minimize the need for system navigation.

Better coordination between home and community providers and hospitals, including access to home and community supports information and providers while in the emergency department, will improve quality of care, promote more effective transitions and provide an opportunity to make better use of existing resources across the system (e.g., adult day or preventative programs).

The new system should leverage existing local partnerships through bundled care initiatives or other hospital and community care direct relationships. The new system navigation models should foster a "care closer to home" philosophy, use shared clinical pathways and build in support for planning quality improvement.

The SMILE program managed by the VON in southeastern Ontario is a promising practice that enables clients and caregivers to manage and navigation multiple services to help them remain at home. OHTs should explore how existing community resources and digital platforms such as 24/7 hub and spoke assisted living models, could be leveraged to offer 24/7 service and online access to system navigation.

[1] Care Navigation: A Competency Framework Health Education England 2016

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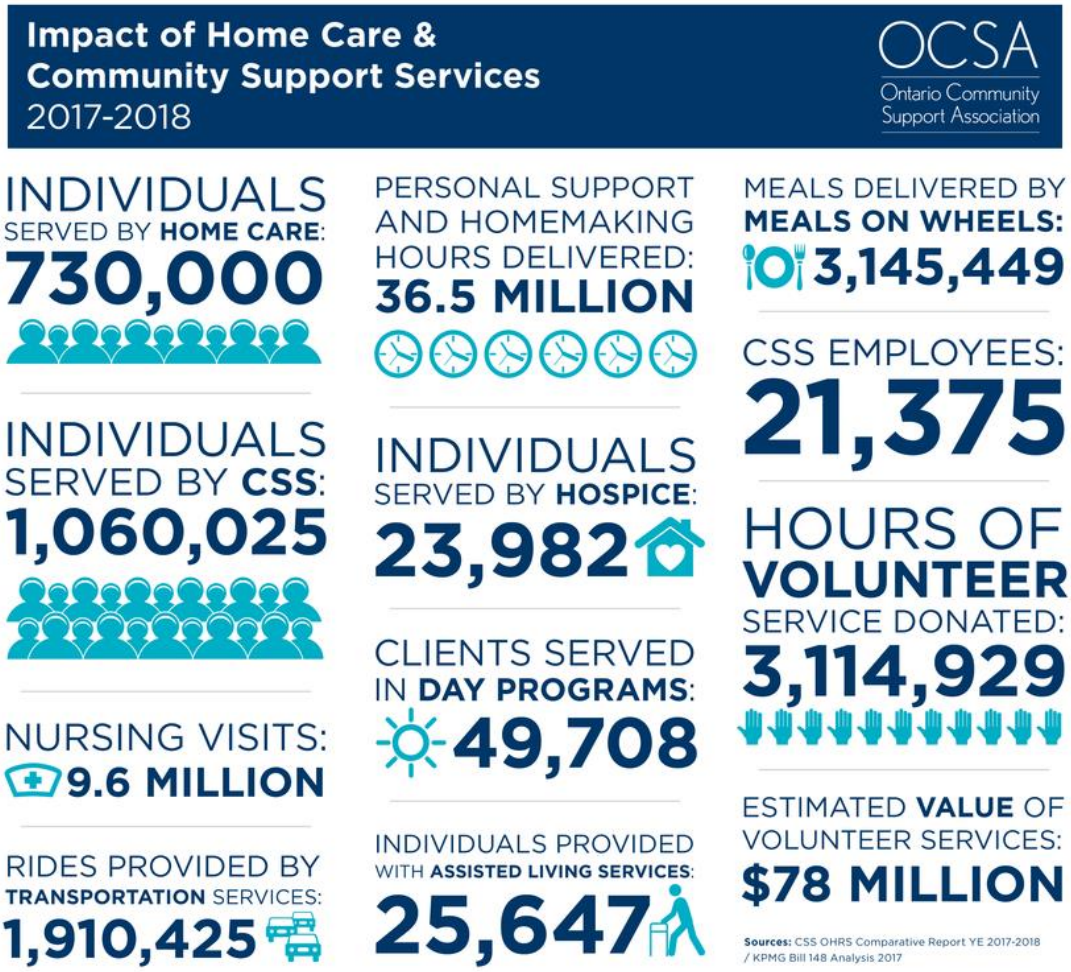
About OCSA

Ontario Community Support Association (OCSA) represents nearly 240 not-for-profit organizations that provide home care and community support services to over one million Ontarians. Our members help seniors and people with disabilities live independently in their own homes and communities for as long as possible. These proactive and cost-effective services improve quality of life and prevent unnecessary hospitalizations, emergency room visits and premature institutionalization. They are the key to a sustainable health care system for Ontario. For more information, visit www.ocsa.on.ca.

For more information please contact: Deborah Simon, CEO deborah.simon@ocsa.on.ca or 416-256-3010 ext. 231



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An overview of home and community care services

Service Type	Funding Source	Delivered By	Access Pathway
Home Care Services			
Nursing Allied health services Personal support Homemaking services	Public funding with many clients supplementing their hours of care with private purchase of additional services volumes	Not-for-profit and for-profit service provider organizations (SPOs)	LHIN Home and Community Care Branch
Independent Living Services			
Attendant outreach Supportive housing Acquired brain injury services Vision impaired care services Deaf, deafened and hard of hearing care services	Public funding and charitable fundraising	Not-for-profit Health Service Providers (HSPs) with Multi-Service Accountability Agreements (M-SAAs)	Program dependent with combination of self-referral, primary care referral and central access
Community Support Services			
Meals and Housekeeping Meals on wheels Congregate dining Home help Home maintenance Rides and Transportation Assisted living services Day services Adult day services Friendly visiting / Security checks Seniors gentle exercise programs Alzheimer dementia services Alzheimer day programs Individual counselling Caregiver support Respite (in home/ overnight) Hospice palliative care	Public funding with client co-pay and charitable fundraising	Not-for-profit Health Service Providers (HSPs) with Multi-Service Accountability Agreements (M-SAAs)	Program dependent with combination of self-referral, primary care referral and LHIN Home and Community Care Branch

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