OCSA
Ontario Community
Support Association

Levels of Care – Feedback & Recommendations

Introduction

The Ontario Community Support Association (OCSA) respectfully submits this paper to inform the Levels of Care development process, as part of the implementation of the *Roadmap to Strengthen Home and Community Care*.

OCSA champions a strong, sustainable home and community support sector for all Ontarians through the provision of a wide variety of clinical and non-clinical services. These services enable hundreds of thousands of seniors, adults and children, including those with long term chronic disabilities, to remain independent and live in their own homes and communities. As the government ponders the development of Levels of Care, it is critically important that these cost-effective services remain a critical part of home and community offerings in order to prevent unnecessary hospitalizations, emergency room visits and premature institutionalization.

OCSA is highly supportive of work to create a Levels of Care (LOC) framework that is person and family-centred and encompasses the full continuum of available of services for clients of the home and community care system.

Our recommendations include:

1. That the levels of care encompass the full range of both clinical (medical) and social services available to clients in home and community care, rather that focus exclusively on home care (acute care).
2. That the levels of care include the broad range of client populations needing access to home and community services, such as adults with long-term chronic disabilities and medically complex children.
3. Concurrent with work on LOC, a capacity assessment and enhancement plan is necessary to ensure that high-quality and sustainable care can be delivered by all parts of the home and community sector.

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Clinical and Social Services Embedded in Levels of Care

Although the concept is in early stages, it is concerning there are references in the document to "home care" in some places and "home and community care" in others. Home care has come to be aligned with the services that are currently delivered through contracts with Community Care Access Centres. This language is confusing and, if intentional, does not address the original intent of applying a LOC framework.

It is our understanding that LOC was intended to provide clients with access to the broad range of services they need to remain <u>independent</u> in their homes and communities. Home care services are mostly targeted at high acuity clinical needs, while more moderate to low acuity care is often supported though community support services such as adult day programs, Meals on Wheels and transportation services, to name just a few examples. Through LOC, a variety of services will be needed in order to provide a comprehensive package of care for clients. Services that support instrumental activities of daily living (IADLs), emotional wellbeing and social activity should be viewed as equally important as clinical services. For example, a frail senior who needs to attend a specialist appointment at the hospital and who has no family to transport them would require transportation services to be included in their service basket. **Given the formidable challenges of meeting an expansive client need in an environment of constrained health care funding, including lower-cost community support services in the LOC framework is critical.**

The consistent assessment of clients within LOC is crucial. This must include assessing not only a client's clinical characteristics, but also their functional status, and social context. **We are supportive of this approach, as described in the discussion paper, and recommend that the interRAI HC *and* interRAI CHA be used by care coordination to gather evidence-based data surrounding client needs.**

The LOC framework has included a level for self-management that we feel is critical. Technological supports such as telehealth and home monitoring could be utilized at this level, as could non-technological supports such as interactive client education and other self-management resource tools. It would also be helpful to expand options to include opportunities to provide flexible funding that allows the client to determine how the resources are spent.

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Existing models including the SMILE program and other client-managed funding programs should be built into LOC.

Lastly, caregiver support is critical at all levels of care. We are pleased to hear that the Expert Panel is working with Dr. Paul Williams regarding his research on the predictors of care needs related to caregiver burnout. Dr. Williams' research indicates that the highest predictors of LTC placement are closely related to caregiver support services available in the community and the impact of caregiver burn-out.

Other Client Populations in Levels of Care

Although one of the largest groups of service users are seniors, it is important that LOC work also include care for other populations dependent on home and community care, such as adults living with long term disabilities and medically complex children. Independent living services delivering care to clients with disabilities are often overlooked when discussing home and community care. Independent living clients are supported in the community, with low reliance on hospital based services, few emergency admissions and few hospital readmissions. The continuity of care is high as is client satisfaction regarding service and quality of life. Care is supported by the use of interRAI CHA assessments, care coordination, and – although not directly funded – case management. The LOC care needs of this population can be high, as many clients are equipment- dependent (ventilator, dialysis). This level of care is safely managed and supported at low cost and high quality in the community. Client care supported in independent living programs often cannot be adequately supported by other programs, such as CCAC services and CSS.

Similarly, medically complex children also require flexible care. In the *Bringing Care Home Report* this population was identified as needing a more unique approach to care delivery, as services and funding cross multiple ministries. For some families, a self-managed model of care would be needed, and for others, care supported by care coordination. **The LOC framework needs to encompass the broad needs of all populations best-served by home and community care, in models that enable their choices and make the best use of the capacity of the health system across the province**.

Capacity Planning for Levels of Care

In order to gain support for the implementation of LOC, clients need to have confidence that the health system has the resources necessary to deliver the care they need. For many years the focus on the acute care system has resulted in inconsistent funding and programming across jurisdictions. The discussion paper indicates that funding has doubled for home and community care over the last decade. However, this funding has not been distributed equitably across all home and community services. **For more than six years, base funding for home and community support providers has remained at 2008/9 levels. This has impacted the sector in many ways: providers have struggled to improve infrastructure, upgrade technology and recruit/retain talent.** Concurrent with developing a LOC framework, work must be done to h assess and enhance the capacity of the full home and community sector to deliver client care.

This capacity planning must align with LOC service needs, so clients can be assured that quality care can be delivered by across jurisdictions by all home and community care providers.

Thank you for the opportunity to be involved in this important and exciting work. OCSA is pleased to continue to offer our members' unique insight, experience, and expertise for further consultation.

Sincerely,

Deborah Simon

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