INTRODUCTION

In *Patients First: A Roadmap to Strengthen Home and Community Care*, May 2015, the Ontario Ministry of Health and Long-Term Care stated its commitment to deliver better coordinated and integrated care in the community and closer to home.

A signature initiative of the Roadmap is to design a Levels of Care Framework. The purpose of establishing a Levels of Care Framework is to ensure that Ontarians receive consistent high quality home and community care regardless of where they live. The framework will introduce common home and community care standards across the province so that patients and their families can be confident that they are receiving the best possible care at home or in the community.

With this paper, we are seeking your input on the ministry’s proposal to design a Levels of Care Framework, and your advice on how to successfully plan for and implement the initiative.

You are invited to review the proposal and submit feedback to: levelsofcare@ontario.ca by October 1, 2016.

HOME AND COMMUNITY CARE IN ONTARIO

In the last decade, the number of people receiving home and community care in Ontario has grown considerably. Home care spans a wide range of services for people of all ages, such as clinical interventions, rehabilitation, palliative and end-of-life care and supports for family caregivers. It is often linked with other essential community-based support services such as meal delivery, homemaking, friendly visits, and transportation services.

Ontario’s home and community care sector provides tremendous value both to Ontarians and to the health care system. Every day, health care professionals and frontline care staff in home and community care put patients first. Receiving support at home allows people the independence and dignity of remaining at home for as long as possible, which is where they want to be. Home care also plays a vital role in supporting the shift in delivery of care from hospitals and long-term care homes to homes and communities, delivering care in the most appropriate and cost-effective way.

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**KEY FACTS**

- Approximately 650,000 people receive home care in Ontario — 60 percent are seniors.
- Nurses make 6.9 million home visits annually.
- 29 million hours of personal support are provided annually.
- 1.7 million therapy visits are provided annually, including physiotherapy and occupational therapy.
- Ontario has more than doubled funding for home and community care since 2003.
THE OPPORTUNITY

While home and community care in Ontario offers excellent care to many, there is opportunity to provide even better home care for Ontarians now and in the future. Transitions from hospital to home could be improved, and many find health care hard to navigate and difficult to understand. Based on our conversations with patients, caregivers, providers, as well as reports from the Expert Group on Home and Community Care, and the Auditor General of Ontario, we know that there is significant variation in both access to and quality of home care services across the province.

PROPOSAL

To ensure Ontarians receive seamless, consistent, high quality care regardless of where they live, we must have clear goals. Patients come first. We must do better to ensure that patients come first.

In conversations with patients and their caregivers, health sector leaders, and experts in home and community care, the ministry has identified four key goals to drive the creation of a successful Levels of Care Framework:

1. Patients First. The delivery of home and community care is centred on the needs of patients and caregivers.

2. Equitable Care. Patients with similar needs receive similar levels of service, regardless of where they live.

3. High Quality Care. Care provided at home or in the community is based on best practice and provincial evidence-informed care standards.

4. Confidence and Trust. Patients and care providers are confident in the expertise of the sector to provide high quality care.

With this document, we begin a process to turn these four goals into a Levels of Care Framework. To meet these goals, Levels of Care will introduce five new initiatives:

1. Levels of Care Framework
2. Functional Support Tool
3. Quality Standards
4. Assessment Policy
5. Home Care Indicators

Each of the five elements of the Levels of Care Framework is outlined on the following pages.
Ontarians want a home and community care sector that is transparent and easy to understand. Patients and caregivers are partners in their own care and they expect to be well informed, so that they can better plan for their current and emerging care needs.

To make home and community care more transparent and provide Ontarians with more opportunities to be engaged in their care, we are proposing to introduce a Levels of Care Framework. The purpose of the framework is to give patients and caregivers a better understanding of what care they can expect at home or in the community, and how their needs for care are assessed.

The framework would be designed such that the highest level represents patients with highly complex needs, while the lowest level represents patients with light care needs. The framework will be based on the patient assessment and will include information in a number of areas, including clinical characteristics, functional status, and social context. For example, a patient’s levels of care would be determined by the type of illness the patient has, and its severity; the patient’s ability to perform what are called “activities of daily living” – e.g., feeding, bathing, toileting; and, the level of support from family and friends. The framework will be flexible in that people can move easily from one level to another, based on changes in their needs.
The framework explores the opportunity to drive the adoption of newer models of care, such as supported self-management through telemedicine and remote monitoring that would allow patients to manage their own health in the convenience of their home.

HOW WILL THE LEVELS OF CARE FRAMEWORK BE USED AND HOW WILL IT IMPROVE CARE?

The Levels of Care Framework will support patients and their families in:

• understanding how their needs are assessed and what level of care can be expected
• participating in needs assessment and care planning.

The Levels of Care Framework will support care coordinators and service providers in:

• evaluating patient complexity, acuity and service intensity needs;
• receiving guidance on developing equitable care plans while maintaining clinical discretion and flexibility;
• communicating and coordinating with providers of other health and social services, including primary and acute care.

The Levels of Care Framework will support health system planners and policy makers in:

• developing capacity plans that include standards for access to home and community care, and improving the client experience across the province.
Presently, patients with the same assessed needs may receive different levels of service depending on where they live in the province. Although there will always be some variation in level of service – for example, some families may choose to receive less support – it is a key priority to ensure Ontarians with similar needs are consistently offered similar levels of support.

The ministry proposes to introduce a Functional Support Tool – a decision support tool that will help care coordinators to develop equitable care plans and allocate home and community care services, such as personal support services.

The Functional Support Tool will stratify clients into distinct levels, from light to very high needs, and give guidance on the level of functional support that a client typically would receive.

An individual's level of care will be based on his or her clinical, functional and social needs as determined through standardized assessment tools, as well as individual preferences and goals of care.

The ministry is currently collaborating with experts in home and community care to develop an evidence-informed and clinically relevant Functional Support Tool.
WHAT WILL THE FUNCTIONAL SUPPORT TOOL DO?

- Give guidance to care coordinators on the clinically appropriate level of personal support when developing a care plan.
- Communicate what patients and caregivers can expect in home care in an easy-to-understand and transparent way.
- Support a similar patient experience, and help patients and their families to be informed partners in their care.

ELEMENT 3:
Quality Standards

There are currently many protocols to guide clinical care in Ontario, but independent analysis on which protocol is most effective is lacking. There are no province-wide standards for which protocol to use, and this may cause variation in both the quality of care and patient outcomes.

Health Quality Ontario is developing Quality Standards that can be used in home care, as part of the broader continuum of care, to ensure that patients with similar clinical conditions are consistently treated using agreed-upon best practices.

Specifically, Quality Standards will foster consistent and high standards in home care by helping patients and their caregivers to know what care to expect for particular clinical conditions, for example, for stroke recovery or caring for a wound. For health professionals, Quality Standards provide guidance for appropriate care delivery that is in line with the best available evidence. Quality Standards are based on what we know works in terms of treatments, procedures, and processes, and will help patients and providers alike to have informed discussions about treatment options.

Health Quality Ontario is currently collaborating with clinicians, patients and caregivers to develop Quality Standards for specific conditions, including wound care, dementia, and palliative/end-of life care.
WHAT ARE QUALITY STANDARDS AND HOW WILL THEY IMPROVE CARE?

• Quality Standards consist of evidence-based statements that define the high-quality care people should expect to receive.
• Patients and their caregivers can use Quality Standards to understand what high quality home care looks like.
• Health care professionals and service providers can use Quality Standards as a guiding tool to deliver quality care consistently and in line with current best evidence.
• Visit www.hqontario.ca to learn more about Quality Standards in home care.

ELEMENT 4:
Home and Community Care Assessment Policy

When a person applies to receive home and community care services, the care coordinator will undertake an assessment with the patient and their caregiver to understand their care needs, strengths and preferences.

Care coordinators use their clinical skills to carry out a holistic assessment of the needs of clients and their caregivers. As part of the assessment process, care coordinators use a standardized assessment tool called the RAI (Resident Assessment Instrument) to gather information about the needs of clients and their caregivers.

With an understanding of what is most important to the client and caregiver, the RAI assessment information and other information such as social circumstances and living conditions, the care coordinator is able to collaborate with the client and family to develop a comprehensive care plan.

Ontario supports the RAI tool in home and community care as well as long-term care settings. The information from RAI assessments is used to track patient outcomes, identify areas where a person has potential for improvement, or where a person may be at risk of decline. Health organizations can also use the clinical data to make evidence-informed decisions on quality initiatives, system planning, benchmarking, and resource allocation.
Home care coordinators in Ontario have used the RAI tool since 2002. The ministry continues to endorse the use of the standardized RAI tools, which enable health care providers to share clinical information across home and community care settings, reduce duplication and ensure that patients and their caregivers are assessed in the same way across the province.

**WHAT IS THE PURPOSE OF A HOME AND COMMUNITY CARE ASSESSMENT POLICY?**

The ministry proposes to introduce an assessment policy to strengthen:

- Patient and caregiver participation in assessment and access to information;
- Clarity about timeframes for assessment and re-assessment;
- Proficiency and training in use of assessment tools;
- Sharing of assessment information between providers;
- How assessment information is used to improve care.

**ELEMENT 5:**

**Home Care Indicators**

The design and implementation of the Levels of Care Framework will be accompanied by an emphasis on performance measurement. Setting standards and performance targets will support our goals to ensure more consistency across the province – and also tell us if the initiatives under Levels of Care demonstrate progress and result in better home and community care for Ontarians.

Health Quality Ontario currently reports on 11 home care quality indicators, including wait times, hospital readmission and patient experience.

Levels of Care will continue to explore ways to improve home and community care and move the sector towards its full potential through new quality indicators.
NEW PATIENT EXPERIENCE INDICATORS

• As part of Levels of Care, the goal is to identify indicators that are most meaningful to patients, caregivers, and the public.

• A new set of patient experience indicators could, for example, include:
  • quality of care (e.g. adherence to Quality Standards)
  • consistency of care (e.g. adherence to recommended service ranges)
  • timeliness of care (in addition to wait times already monitored by Health Quality Ontario)
  • level of involvement in care plans
  • connections between care providers, including home care, primary care, and hospital care
  • access to information

NEW SERVICE TARGETS FOR HOME CARE

• We propose to identify a number of new service targets to track progress in improving consistency of care.

• These targets could include:
  • number of people who receive care according to Quality Standards
  • number of people who receive care within recommended service ranges as defined by the proposed Functional Support Tool

HOW WILL HOME CARE INDICATORS HELP IMPROVE CARE?

• Reporting on measures of home care can help shine light on how well the system performs.

• By publicly reporting data on quality and consistency of care, home care providers strive for transparency and accountability, and use that data to drive quality improvement.
HOW DOES LEVELS OF CARE BENEFIT ONTARIANS?

The story of Ms. Lee highlights what the proposed Levels of Care Framework would mean for Ontarians.

MEET MS. LEE

Ms. Lee is a 76-year old widow, who lives alone. Her only son lives an hour away and occasionally visits on the weekend.

Lately, her son has noticed that his mom appears unkempt, and her clothing is wrinkled and stained. Her apartment is cluttered, and other than a carton of milk, the fridge is bare. Sometimes she forgets where she is. Recently her son received a call from the local supermarket, because Ms. Lee was confused about how she would get home.

ASSESSING MS. LEE’S NEEDS

Ms. Lee’s son calls the local Community Care Access Centre (CCAC) to get help. A care coordinator visits Ms. Lee in her home to learn more about her needs. This visit occurs within a time specified by a provincial standard.

The care coordinator interviews Ms. Lee and her son using a standardized assessment tool to determine her needs, strengths and preferences. Using his assessment skills, as well as his clinical expertise, the care coordinator is aware that Ms. Lee could have symptoms of dementia. Her son believes his mom is just showing signs of normal ageing.

The care coordinator shares a Quality Standard that includes recommendations about detecting and diagnosing dementia for Ms. Lee’s son to review. He decides to follow up with the family doctor, based on the care coordinator’s recommendation. The family physician takes a history, conducts a physical examination, and orders a few blood tests to rule out conditions that can mimic or cause dementia. The family physician calls the care coordinator to better understand the home situation and the family’s concerns.
DEVELOPING A PLAN OF CARE

Based on the family physician’s assessment, Ms. Lee is diagnosed with dementia. The care coordinator works hand in hand with Ms. Lee, her son and the family physician to determine what care Ms. Lee needs and develops an individualized plan for care. The care plan includes:

• in-home personal support services;
• occupational therapy;
• a referral to a local memory clinic;
• supports from the Alzheimer’s Society; and
• ongoing coordination of care.

HOW IS THE FUNCTIONAL SUPPORT TOOL USED?

The care coordinator uses the Functional Support Tool to provide guidance in assigning the level of personal support Ms. Lee will receive. By using this tool the care coordinator is assured that the service level is clinically appropriate and consistent with the level of care provided to similar patients elsewhere in the province.

The Functional Support Tool identifies Ms. Lee as having moderate functional support needs and suggests three to six hours of personal support per week. This service range is based on an evidence-based formula which predicts the need for personal support. Ms. Lee’s ability to eat, bathe and dress, her cognitive ability, and the extent of support from family and friends are important factors in determining the level of support she needs.

Using his clinical expertise and judgement alongside the information from the Functional Support Tool, the care coordinator arranges for Ms. Lee to receive five hours of in-home care by a personal support worker.

HOW IS THE QUALITY STANDARD USED?

The personal support worker and occupational therapist supporting Ms. Lee are well-equipped to support the unique needs of dementia patients.

Both providers follow the Quality Standard for early-onset dementia which recommends strategies to use when caring for clients with dementia.

• The personal support worker uses recommended practices on how to address specific aspects of care, such as pain, food consumption, and behavioural symptoms.
• The occupational therapist works with Ms. Lee to develop ways to compensate for limitations and maintain independence through skills training, adaptations to her home and use of assistive technology.

The Quality Standard is also available to Ms. Lee’s son so he feels educated about his mother’s condition and knows what to expect both in terms of care and disease progression.

**FOLLOW-UP**

Ms. Lee and her son are informed that the amount of care Ms. Lee will receive will increase as her condition progresses, and that long-term care may need to be considered at some point in the future. Ms. Lee’s care plan is documented and shared with Ms. Lee, her son, and everyone in the circle of care, so all are aware of what to expect. Ms. Lee and her son also know where to go if they need help, or if their care needs or circumstances change.

In two months, Ms. Lee will go for a follow-up visit with the family doctor. The care coordinator will continue to support Ms. Lee and will re-assess her needs at regular intervals, consistent with the Quality Standard, to ensure that the type and level of care continues to be appropriate.

**HOW IS THE PATIENT AND CAREGIVER EXPERIENCE IMPROVED THROUGH THE LEVELS OF CARE FRAMEWORK?**

• Clients and their families will know what to expect in their care, and they experience easy access to their care.

• Patients and their families can be confident that they will receive high quality home and community care, regardless of where they live.

• Care coordinators will have the tools they need to develop equitable and consistent care plans.

• Care providers will use province-wide care standards and protocols to ensure that the best possible care is provided.
YOUR VIEWS

The ministry invites you to submit your response to this discussion paper. Questions of particular interest include:

1. What are your views on the proposed Levels of Care Framework?

2. How do we ensure that the Levels of Care Framework is responsive to the needs and preferences of patients and their caregivers?

3. How do we strengthen consistency and standardization of home and community care while maintaining flexibility to respond to individual needs and local circumstances?

4. Are there opportunities or barriers to implementing the Levels of Care Framework that should be explored further?

5. What areas of performance should be highlighted through public reporting to drive progress in home and community care?

6. Is there any other advice that you would like to provide?

Your feedback does not have to address these questions and may respond to other issues raised in this paper. Feedback can be emailed to: levelssofcare@ontario.ca and will be accepted up to October 1, 2016.