CARE WATCH
Advocating Quality Home & Community Care

June 1, 2017

Levels of Care Update – *Thriving at Home Report*

A Report entitled ***"Thriving at Home"*** was released by the Ministry of Health and Long-Term Care on June 1, 2017. Care Watch made submissions to the Ministry of Health and Long-Term Care respecting the development of a "levels of care framework" (LOCF), as well as contributed to two stakeholder workshops. The Ministry's report is available at: http://health.gov.on.ca/en/public/programs/lhin/docs/loc_report_2017.pdf.

The levels of care discussion is relevant to Care Watch's (CW) position that **every senior in every community in Ontario should have access to a comprehensive basket of supportive home services,** regardless of where they happen to live.

The Expert Panel's LOC proposals support CW's position that a standard Basket of Services which all seniors should be able to access be established by regulation.

CW now calls on government decision-makers to identify and earmark the resources needed to implement the LOCF in a transparent and equitable manner.

The following is a summary and assessment of key points of the Levels of Care Framework (LOCF).

HISTORY OF CW ADVOCACY ON LOC:

In 2016, Care Watch wrote to Health Minister Eric Hoskins and Ministry senior officials in response to a consultation document entitled *Levels of Care Framework: Reporting Back on What We Heard* (November 2016). While applauding the proposed emphasis on flexibility and responsiveness to individuals and their caregivers, and in recognition of the critical role of the home and community care sector, Care Watch:

- Stressed that home care and community support services should not be limited to "patients" or the "most vulnerable", but be available to all seniors who require such assistance;
- Noted the importance of addressing the social (non-medical) determinants of health, the need to identify the services to be provided at each level of care, and the importance of other ministries, as well as municipalities, working together to provide the necessary service array to ensure that senior citizens and others requiring such services can, in fact, access and benefit from home care and community supports;
- Supported the idea that delivery of home and community be centered in the needs of individuals and their caregivers and not be directly linked to the illness-care or medical system to avoid the medicalization of ageing, which was evident in the original *Patients First* vision;

- Strongly advocated for an equitable home and community care policy that was: (1) based on the same principles as the *Canada Health Act* (CHA) of public administration, comprehensiveness, universality, portability and accessibility; and, (2) supported by a funding commitment that originates in the tax system and includes earmarked or designated funding that is quarantined against leakage to the acute care service system;
- Advocated clear communication of what Ontarians may expect to receive at home or in the community; the services included in each proposed level of care; assessment and consideration of caregiver capacity in determining the services provided; and coordination of services mechanisms; and
- Sought clarity (or at least a discussion) of how services would be funded, proposing that community support services (CSS) be supported by a funding commitment that originates in the tax system and includes earmarked or designated funding that is quarantined against leakage to the broader acute care service system.

We followed up in May 2017, advocating that CSS be delivered only by not-for-profit organizations, which allows for funding to be directed to care or service rather than profit, and leverages the immense value volunteers provide to the sector; and that not-for-profit service delivery be established in regulations.

Fun Facts shared in the Report:

- *About 560,000 Ontarians received home care services provided by the province's Community Care Access Centres (CCACs). They received a total of 28.7 million personal support and home-making hours, 6.9 million nursing visits and 2.1 million nursing hours, 1.7 million therapy visits (physiotherapy, occupational therapy, speech language therapy, social work) and 1.9 million case management visits. (Data provided by Health Shared Services Ontario. March 2017)*
- *About 675,000 Ontarians received just under 1.17 million visits and services from Ontario's 661 community support service agencies, which provide meal services, transportation, caregiver support services, home maintenance and repair services, friendly visiting and other services. (Data provided by Health Data Branch, Ministry of Health and Long-Term Care. March 2017).*
- *85 per cent of individuals who received personal support services through CCACs needed those services for more than six months. For those individuals, their services cost an average of $717 a month, compared to $371 for the seven per cent who required care for 60 days or less, and $1,006 for the eight per cent who required end-of-life support. (Data provided by Health Shared Services Ontario. March 2017.)*

Overview of Framework:

The Framework focuses on the **functional needs**[1] of adults who need home and community care for several weeks or longer. The rationale for this is that "…adults who need care for a short time (known as short-stay) have usually been discharged from hospital after surgery or treatment, and they mainly need nursing care and rehabilitation services. If they do need help with functional needs, it will be for a very short period of time".[2] While the Expert Panel argues that the Framework can be used with short-stay adults, they feel it will have the greatest impact and be most useful with adults who need on-going help with their functional needs. ***CW supports this approach***.

The Framework "… is intended to ensure that regardless of where people live in Ontario there is consistency in the way people are assessed and in the process used to determine the amount and type of care that each individual might receive". To achieve this end, implementation of a combination of standardized tools, clinical judgment, and input from the person and caregiver to inform care planning is proposed.

CW agrees that standardized tools should be employed in care planning, but is concerned that there is no corresponding assessment of the resources required to implement such tools.

The Expert Panel also recommends that:

- Individuals who can physically attend clinics and outpatient services should receive their clinical services in those settings if they exist in their regions; and
- Individuals who, due to their physical health condition, cannot attend clinics and outpatient services should receive clinical services in the home.

CW agrees with these proposals, but emphasizes that regional availability of a full range of services is still only a dream for most Ontarians residing outside metropolitan areas. Additionally, clear implementation tools, strategies and resources are required for implementation.

Finally, the Panel also advises that children and youth who need home and community care would be best served by a distinct and separate Framework.

Key Features of the Framework include:

- Assessment based on ***total functional needs***: more specifically … "on what the individual cannot do independently, regardless of who assists them with these activities". In planning care and deciding how much home care services the person will need (service "volume" or "intensity"), the care coordinator will consider the *capacity of caregivers* to assist, as well as any distress that caregivers may be experiencing.

[1] Functional needs refer to a person's ability to perform: (a) **activities of daily living (ADLs)**, such as personal hygiene, bathing, eating, toileting, and moving from a bed to a chair; and (b) **instrumental activities of daily living (IADLs)**, such as home maintenance, preparing meals, shopping for groceries or clothing, banking, and taking medications.

[2] Expert Panel on Levels of Care Report.

- Care planning based on unmet functional needs … to determine the type and amount of supports to be provided, taking into consideration "… all possible sources of support".
- Use of modifiers to determine service needs within a level. Modifiers that may affect needs include:
  - ❖ Complex social issues such as: low income; unstable housing; living alone; complex family dynamics
  - ❖ Complex health issues, such as: a mental health condition (e.g., depression) or an addiction; significant cognitive impairment (e.g., dementia); multiple medical conditions
  - ❖ Caregiver availability and capacity, including lack of caregiver and distressed caregiver
  - ❖ Monthly hours (versus weekly hours) to provide flexibility in when individuals and caregivers determine when they need support rather than fit in to a fixed schedule.
  - ❖ Home and community care services complement the support provided by caregivers, including: primary care, a comprehensive specialized geriatric assessment and dementia supports, assistive devices and appropriate rehabilitative programmes, either at home or in their community, and coaching and education for care givers.
- Appointment of a *Care Coordinator* responsible for working with the individual/caregivers to develop a care plan and arrange and coordinate services, facilitate access to appropriate community support services and other programmes (some or all of which may be on a fee basis).

CW supports these proposals.

Primary Caution: there is no money attached to the report and it is not clear how the Province will fund its implementation!

Figure 2: Proposed Levels of Care Framework[****]

LEVEL OF CARE	FUNCTIONAL NEED PROFILE*	TOTAL SUPPORT HOURS PER MONTH**, ***
1	The person is independent in terms of personal care (ADLs) but needs assistance with some IADLs, such as home maintenance and meal preparation. The person does not need personal support but may benefit from community support services such as assistance with transportation or home maintenance, as well as education, exercise and socialization programs.	community support services only; no need for personal support
2	In addition to the needs at Level 1, the person may need assistance with medication management and help or supervision with some personal care activities, such as bathing (e.g., getting in and out of the tub). Individuals at this level do not need assistance every day. They may also benefit from community support services, and from some assistive devices (e.g., cane, walker).	up to 12 hours
3	In addition to the needs at Level 2, the person needs assistance with most IADLs and may need assistance with ADLs such as bathing, moving around in the home, and dressing. Individuals at this level may need assistance every day. They may also benefit from community support services, assistive devices, and caregiver coaching programs.	up to 32 hours
4	In addition to the needs at Level 3, the person needs additional help with transferring and toileting. Individuals at this level may need assistance once or twice per day. They may also benefit from community support services, assistive devices, caregiver respite, and caregiver coaching programs.	up to 56 hours
5	In addition to the needs at Level 4, the person needs extensive assistance with personal hygiene and bathing, and may need help with eating. Individuals at this level may need assistance two or three times per day. They may also benefit from community support services, assistive devices, caregiver respite, and caregiver coaching programs.	up to 84 hours
6	In addition to the needs at Level 5, the person needs extensive help with eating and locomotion, and may need two people to assist with transferring. Individuals at this level may be unable to leave their bed, or may spend extensive periods of time in a chair. They may need assistance three or more times per day. They may also benefit from community support services, assistive devices, caregiver respite, and caregiver coaching programs.	up to 120 hours
7	The person needs assistance with all IADLs, needs extensive help with all ADLs, and cannot be left alone for long periods of time. Individuals at this level may be unable to leave their bed, or spend long periods of time in a chair. They are experiencing exceptional circumstances, such as nearing end of life, awaiting crisis placement to long-term care, a short-term emergency, or a caregiver who is ill or hospitalized. They need frequent assistance throughout the day. They may also benefit from community support services, assistive devices, caregiver respite, and caregiver coaching programs.	above service hours in level 6

Notes to the Framework:

* Based on Expert Panel advice, taking into consideration the interRAI IADL-ADL Functional Hierarchy Scale.

** For the purposes of this framework, a month is equal to 4 weeks.

*** Individuals who do not need the offered level of support at the time of the assessment are still eligible to receive it at a later date.

****Ministry of Health & Long Term Care. (2017). *Thriving at Home: A levels of care framework to improve the quality and consistency of home and community care for Ontarians. Final report of the Levels of Care Expert Panel.* p16. Toronto, ON: Author.