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

Dipti Purbhoo, Home and Community Care Expert

Irfan Dhalla Vice President, Evidence Development & Standards, HQO

HSSOntario Achieving Excellence Together Conference

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Patients First: A Roadmap to Strengthen Home and Community Care

- Based on recommendations from the Expert Group on Home and Community Care, Ontario announced *Patients First: A Roadmap to Strengthen Home and Community Care*, a 3-year 10-step plan to improve and expand home and community care.
- The Levels of Care Framework is a key commitment of Roadmap.

1. Develop a Statement of Home and Community Care Values
2. **Create a Levels of Care Framework**
3. Increase Funding for Home and Community Care
4. Move Forward with Bundled Care
5. Offer Self-Directed Care
6. Expand Caregiver Supports
7. Enhance Support for Personal Support Workers
8. Increase Nursing Services for Patients with Complex Needs
9. Provide Greater Choice for Palliative and End-of- Life Care
10. Develop a Capacity Plan

Report of the Expert Panel on Home & Community Care

Donner et al, March 2015

Themes

- Client & Family-Centred Care
- Support for Caregivers
- Basket of Services – clarity about what services are available
- Better coordination and integration of services
- Improved Approaches to Service Delivery (e.g. IFMs)
- Focus on Quality, Performance Indicators and Accountability
- Importance of Primary Care
- Need for Capacity Planning

16 Recommendations

The Levels of Care Expert Panel

- In August 2016, the government of Ontario established the Levels of Care Expert Panel (Expert Panel) to provide evidence-informed policy recommendations and operational advice related to the design, implementation and evaluation of a Levels of Care Framework for home care.

- The Expert Panel was asked to develop a Levels of Care Framework that would group people into care levels based on their needs and service ranges for each level, advise on tools to help assign clients to care levels and allocate services, and advise on a provincial assessment policy.

- The Expert Panel was not asked to make recommendations related to resources, funding, or the organization of the home and community care system; however, we recognize that many of our recommendations have implications for these issues.

- Our final report, Thriving at Home, was submitted to the ministry in May 2017. It is now publicly available at http://www.health.gov.on.ca/en/public/programs/ccac/

Levels of Care Expert Panel Membership

The Levels of Care Expert Panel is a group of individuals with wide-ranging expertise in home and community care, including:

- people who receive home and community care
- caregivers
- care coordinators
- service providers
- physicians
- researchers
- experts in evaluation and quality improvement.

Member	Organization
Dipti Purbhoo (Co-chair)	Toronto Central CCAC
Irfan Dhalla (Co-chair)	Health Quality Ontario
Karyn Lumsden	Central West CCAC
Ian Ritchie	North West CCAC/Toronto Central CCAC
Scott Wooder	Hamilton Family Health Team
Chase McMurren	Taddle Creek Family Health Team
Valerie Winberg	Twin Bridges Nurse Practitioner-Led Clinic
George Heckman	University of Waterloo
Joanne Greco	Closing the Gap Healthcare Group
Lori Holloway	Bellwoods Centres
Walter Wodchis	University of Toronto
Heather Binkle	Health Shared Services Ontario
Janet Daglish	Bayshore Home Health Care
Katherine Chan	Patient Representative
Sharon Livingstone	Caregiver Representative
Crystal Chin	Patient Representative
Melanie Murray	Champlain CCAC
Jane Matheson	Hamilton Niagara Haldimand Brant CCAC

What is the Levels of Care Framework?

The Levels of Care Framework is an approach to ensure that Ontarians receive consistent, high quality home and community care regardless of where they live, through a standardized approach to assessing need, and the transparent and understandable assignment of home and community care services.

Guiding Principles for a Levels of Care Framework

Inclusive Will respond to the needs of all individuals who seek home and community care	**Transparent** Will be user-friendly and understandable	**Evidence-Informed** Will reflect available evidence regarding service needs
Nimble Will be able respond to changes in care models, practice, and technology	**Fiscally Responsible** Will set realistic care levels that can be sustainably resourced	**Population-Specific** Will be tailored to reflect and meet the needs of a specific population
Needs-Based Will respond to individuals' assessed functional, medical and social care needs	**Flexible** Will support individualized care by engaging individuals and families in care planning	**Responsive** Will enable people to move between levels of care as their needs change

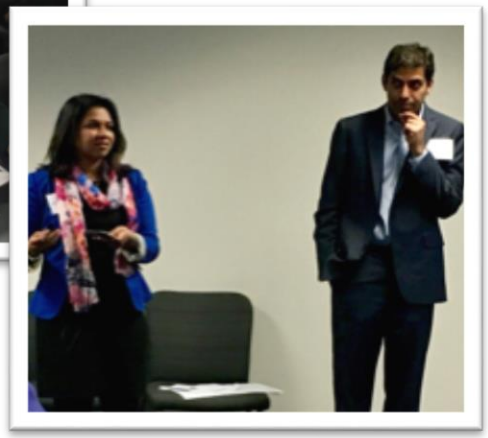
Benefits of the Levels of Care Framework

- Enables a consistent process for evaluation of client complexity and service intensity needs
- Ensures clients with similar needs are offered similar care regardless of where they live
- Establishes a common assessment and reporting language across health care settings
- Provides transparency in how the assessment and care planning process is undertaken

Expert Panel Activities: Research and Consultation

Examined best practice and research

- Reviewed current approaches from various jurisdictions
- Considered different assessment tools and approaches
- Examined relevant data on home and community care services in Ontario, and other provinces and territories



Sought advice

- Feedback from 150 Levels of Care Workshop attendees
- Feedback from Patient and Caregiver Advisory Table, and the Home and Community Care Advisory Table
- Held a half-day focus group with 20 care coordinators
- Held a full-day development session with 118 stakeholders

Recommendation #1:
Levels of Care Framework

Level of care	Functional Need Profile	Total personal support hours per month
1	Only requires assistance with day-to-day activities such as banking and meal preparation.	Community support services only; no need for personal support
2	Level 1 plus assistance with some personal care activities such as bathing, and day-to-day activities, and may need some assistive devices (e.g. cane). Does not need assistance every day.	up to 12 hours
3	Level 2 plus assistance with some personal care activities and most day-to-day activities, and may also benefit from a caregiver coaching program. May need assistance every day.	up to 32 hours
4	Level 3 plus additional assistance with transferring and toileting, and may also benefit from caregiver coaching and respite. May need assistance once or twice a day.	up to 56 hours
5	Level 4 plus extensive assistance with hygiene and bathing, and may need help with eating. May also benefit from caregiver coaching and respite. May need assistance two or three times a day.	up to 84 hours
6	Level 5 plus extensive help with eating and locomotion, and may need two people to assist with transferring. May also benefit from caregiver coaching and respite. May need assistance three or more times a day.	up to 120 hours
7	Reserved for individuals with short-term or extraordinary needs. May need frequent assistance throughout the day	Above service hours in Level 6

Recommendation #2: Assessment and Reassessment

i. Establish a standardized, person-centred, culturally sensitive assessment process

- Self-assessment tool for individuals and caregivers
- An initial formal, standardized comprehensive assessment that uses both the interRAI suite of tools and clinician judgment
- Summary of the assessment results and recommendations shared with the client/family and care team
- Ongoing informal assessments of the individual's needs, and the caregiver's capacity, by all members of the care team over the course of providing services
- Check-in visits (in person) by the care coordinator for an individual assessed at level 4 and above at least every six months (or more frequently depending on the complexity of the person's and family's needs)
- A formal reassessment
  - At least every 12 months, and
  - Whenever the person's functional needs or the caregiver's capacities change significantly
  - When the family requests a reassessment
  - When a reassessment is requested by any member of the care team
  - When the home and community care coordinator determines it is necessary

Recommendation #2: Assessment and Reassessment

ii. Optimize the assessment process and create a shared interRAI platform, including:

- Refining current assessment tools, making them shorter, easier and faster to use
- Developing a short standardized assessment tool for check-in visits and follow-up calls
- Identifying triggers for a formal reassessment

iii. Harmonize the assessment process and assessment tools across the home and community care sector

Recommendation #3: Person- and Family-Centred Care Planning

i. Promote a person- and family-centred care planning process

ii. Individuals/families should have the right to request a review of their assessment and any element of the care plan

Recommendation #4: Culture

All ministry policies and communications, and all home and community care processes and practices continually reinforce that:

- The primary goal of home and community care is to enable people with health and functional needs to maximize their independence and thrive in their homes and communities
- Individuals and caregivers are key members of the care team and active partners in care planning
- Publicly funded home and community care services complement the care and support provided by caregivers to the degree that these individuals have the capacity to provide care

Recommendation #5: Service Integration

Support for Service Integration:

- Across the Home and Community Care Sector as one sector
- Integrate care between the Home and Community Care Sector and Primary Care

Recommendation #6: Care Coordination

Recognize care coordination as a critical home and community care service

Work should be done to:

- Clearly define the role of home and community care coordinators
- Identify the skills and competencies care coordinators need
- Establish standards and expectations for home and community care coordinators including expectations about management and delegation of responsibilities to other health care team members (e.g. clinical managers, nurses, personal support workers, team assistants), and consistent methods of communication/collaboration with primary care providers and specialists
- Develop standard professional development programs
- Ensure that care coordinators have the right tools, technology, and capacity

Recommendation #7: Information Systems

Develop policies to guide data sharing agreements and electronic information systems that are integrated with existing system to:

- Information sharing across the care team
- Reduce duplicative assessments and unnecessary administrative burden to optimize time for care provision

Recommendation #8: Quality Improvement

i) ***Evaluate the framework and ensure it is applied consistently by:***

- Gathering data from the standardized assessments and resource allocations
- Establishing indicators of success and effectiveness, both at the individual and system levels

ii) ***Ensure evidence based quality standards for clinical and rehabilitation services established by Health Quality Ontario are followed***

iii) ***The ministry should invest in home and community care research to:***

- Assess the impact of care provided in the home, and provide evidence to guide policies and programs
- Identify best practices in terms of the amount and type of care that people need to thrive at home and maximize their independence

Recommendation #9: Transparency and Public Communication

i. ***Establish and promote a provincial website or portal where people can access information about***:
   - Home and community care services available in Ontario, and what the system can provide
   - The framework and assessment process
   - The client self-assessment tool
   - Links to their LHIN's home and community care services

ii. ***Continue to enhance public reporting on the quality of home and community care in Ontario***

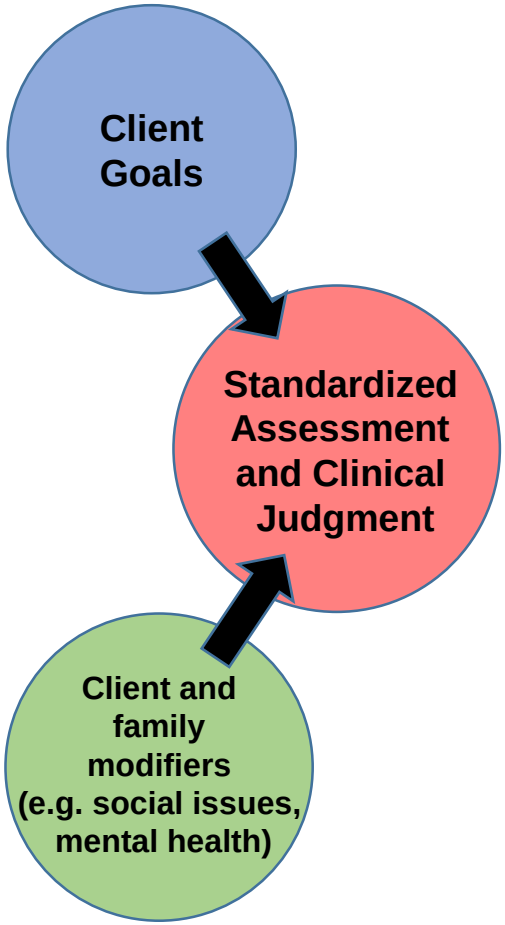
Recommendation #10: Out-of-Scope Issues

i) ***Establish an Expert Panel to develop a framework for home care services for children with medically complex needs. Focus should include smooth transitions to adult services***

ii) ***The Ministries of Health and Long-Term Care and Community and Social Services should work together to address the home and community care needs of people in developmental services programs***

The Levels of Care Process

Care Planning Process



Levels of Care Framework and Care Plan

Levels of Care Framework	
CSS only	1
Up to 12 hours	2
Up to 32 hours	3
Up to 56 hours	4
Up to 84 hours	5
Up to 120 hours	6
Above 120 hours	7

Optional client-centred opportunities

What do I need help with?
Client self-assessment

- ☐ Meal preparation
- ☐ Transportation

- ☐ Bathing
- ☐ Help every few days

- ☐ Most day-to-day activities
- ☐ Help once or twice a day

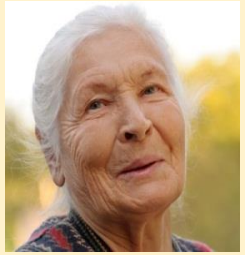
- ☐ Toileting
- ☐ Caregiver coaching

- ☐ Some help with eating
- ☐ Caregiver respite

- ☐ Bed-to-chair transferring
- ☐ Help three or more times per day

- ☐ Short-term extraordinary needs

What Home and Community Care Should Look Like


What care do I need?	*How do I receive it?*	*Thriving at home with home and community care*
• Levels of Care website • Client self-assessment tool • Standardized assessment and individualized care plan by a health care provider	• Optimized care coordination • Integrated and person-centred home and community, primary, and specialist care • Clients and caregivers play a central role in their care planning • Access to a plain language summary of the assessment	• Standardized care • Consistent and equitable assessment and care coordination policies • Real-time information sharing between all members of the circle of care