Home and Community Care Review

Stakeholder Survey

PLEASE MAKE YOUR VOICE HEARD!

The Home and Community Care Expert Group (the Group) has been asked by the Minister of Health and Long-Term Care to provide specific, practical recommendations to the Minister to bring the home and community care sector to a more integrated, accessible, responsive and equitable system for individuals in need and their caregivers (both paid and unpaid).

The Group will provide its recommendations to the Minister by the end of January 2015. Given the short time frame and our desire to hear from individuals and their families/ unpaid caregivers who use the programs and services as well as those who provide the services, we have developed five focused questions to aid us in our work.

YOUR INPUT IS VERY IMPORTANT TO US

How to Submit Your Responses

To submit your input:

1. Visit https://www.surveymonkey.com/s/homeandcommunitycarereviewsurvey to submit your responses online
2. Mail your responses to the Home and Community Care Expert Group:

   Home and Community Care Review
   PO Box 29612 Central Parkway PO
   Mississauga, ON L5A 4H2

3. Email your responses to the Home and Community Care Expert Group email address:

   homeandcommunitycarereview@gmail.com

Please reply by October 31, 2014

Homeandcommunitycarereview@gmail.com
P.O. Box 29612, Central Parkway PO
Mississauga, Ontario, L5A 4H2

Home and Community Care Review

Stakeholder Survey Questions

To help in our deliberations, please respond as specifically as you can to the following questions:

1. What are the three greatest sources of frustration for individuals in need and their families/unpaid caregivers who are receiving home and community care? What are the home and community care sector's three greatest successes? What specific change(s) could be made to address these frustrations and/or build on these successes?

Sources of Frustration	Recommended Changes
There is a lack of or inappropriate use of therapy professionals – high risk clients are not referred to therapy or inadequate levels of service are authorized or not at the right time. Our members hear comments from clients such as the following: • It would have helped if you had been here 3 months ago • You are only going to teach me how to use this piece of equipment? There is no treatment? • All this paperwork and only one visit?	• Care coordinators at CCAC's should be empowered to act on CAPS triggered by the RAI assessment tool (we know that a large percentage of clients who would benefit from rehab – as indicated by the RAI – do not receive it) • Reframe purposes – i.e. rehab as a priority by CCAC's – there is a significant lack of focus on a restorative approach for home and community clients. With PT Reform, there has been some advancement for physiotherapy, but it is inconsistent across CCAC's. There are some models of restorative services that have been successful in reducing overall dependence on the health system – these should be replicated, but when funding is scarce, such quality programs are eliminated • Engage with experts re appropriateness of when to refer to therapy disciplines (see attached Reference Guide) – this can include when to refer to a therapist, Social Worker, or Registered Dietitian, when their particular expertise would most benefit clients • Unregulated Care Providers (i.e. Occupational Therapy or Physiotherapist Assistants, or Communicative Disorders Assistants) can be appropriately incorporated into care based on client needs and the determination of the regulated provider.

	They must be competent individuals, with appropriate training with access to the regulated provider for appropriate supervision
Perceived multiple levels of coordination and lack of consistency (hospital, community coordinators) – in particular at transition time CCAC Client Care Coordinators are seen as gatekeepers – not coordinators of care. Clients and families need help understanding the maze of services and supports available, as well as criteria for eligibility. There can be frustration reaching Care Coordinators, who may not be in the office or have sufficient time for engagement with clients and caregivers.	• Need one point of access to system navigators who fulfil both information and referral roles, and who have an in-depth knowledge of local resources/eligibility. • Need access to supportive services – i.e. Social Work • Technology may be beneficial in this area: perhaps a Home and community "App", as well as a common electronic record that crosses settings
Not enough in home support when needed – direct care (rehab, respite, activation) • Some clients are deemed ineligible – turned away at the door • With closure of some OPD services, no availability of some publicly funded services in community • Rationing – e.g. referring only one service and asking that provider to cover what another would be better prepared to address	• There is a need for an overall increase in funding to community care sector to recognize the shift of clients from hospital and Long-Term Care to community, and the growth in client numbers and complexity

Greatest Successes	Building on Success
Successfully caring for some very complex people in home environment • people dying in the location of their choice • Home First • Stay at Home • Some of these are costly in terms of use of CCAC budgets, but less expensive than institutional care • Paediatric population – caring for some children with many medical and developmental complexities, including those who are dependent on technology for survival	• Appropriate levels of funding- need to be allocated to meet needs – and to ensure that the full complement of services are available in home. • Funding levels need to rise in home and community care to reflect early discharge of clients and the related costs to deliver care • Evaluative pilots should be formally considered and reviewed to allow for shared learnings and rollouts of successful initiatives across CCACs

Interprofessional collaborative care – potential for success • Done well in some places – not done enough and consistently	• CCAC's need to order the full range of services as needed to meet client and caregiver needs • Need more engagement by Care Coordinators with clients/families/providers – for example in facilitating case conferences, a practice that has decreased dramatically over the last several years • There are models of interprofessional care being delivered in home and community in other provinces and international jurisdictions that provide models for consideration.
Skills and quality of individuals delivering service in community	• There may be lack of confidence among colleagues in other sectors about referring to in home services – there is a need to showcase the specialized skills of providers delivering in home care • Note that there is a risk of losing skilled providers as services are cut (i.e. therapy services)

2. What are three specific changes you believe would increase the coordination and integration of services (e.g., hospital transitions, primary care, home and community care, social services) for individuals in need and their families/unpaid caregivers so that they can be active participants in planning and managing their own care and be well supported in that role?

Changes	Current State
Common, easily accessible health record that crosses settings – accessible by all providers as well as by client/caregivers as part of the care team.	• Reports from all providers are held by CCAC – although there may be sharing if members of team are in the same organization; there is limited sharing by CCAC • Detailed progress records are held by individual service provider organizations • Little information is requested/required by CCAC's – mainly related to billing authorization • Inconsistent cross-sectoral access (e.g. acute <-> community)

Clarify eligibility criteria – who does what for which clients in which settings – to facilitate communication and awareness of who ought to be collaborating with clients and families. There needs to be transparency with clients/families/providers in other sectors regarding these criteria.	• There has been a recent shift related to reduced resources – in effect, only most complex and at risk clients are being seen, but this is not clearly made known • The variable governance and funding across CCAC's creates inconsistency. Lack of consistent resources based on population needs leads to variable practices in deeming who is eligible (e.g. some CCAC's have deemed that they do not fund treatment for communication) • Roles of community care service providers and CCAC vis a vis the provision of PSW supports is poorly understood. • Role of primary care sector in supporting self management within potentials is unclear and inconsistent.
Further develop system/processes to support timely system navigation and referrals: • Technology • Care Coordination • Information for other providers of service to facilitate information and referral • Earlier involvement to support health promotion/early intervention	• There is a lack of clarity of the role of CCAC Care Coordinators, especially in relation to cross sectoral issues (linkage with primary care, role in relation to community care services, etc.) • There must be a mechanism to assess and meet the needs of those who are not eligible for CCAC services (e.g. those streamed to CSS sector for PSW or those that could benefit from therapy supports but are not homebound and may therefore not be eligible for CCAC services)

3. What are three specific ways that **providers of home and community care** could better meet the needs of individuals in need and their families/unpaid caregivers?

Ways to Meet Needs	Current State
Provide support for clients/families outside the "face to face" visit	• there is a financial disincentive for CCAC contracted providers to provide support to clients/families outside of the face to face visit –

• Not to replace assessment/intervention that should take place in person by the most appropriate professional • Need support via a compensation model for broader involvement of service providers (instead of fee for service model that allows compensation for face to face interactions only)	reduces participation by clients and families.
Therapy services to promote wellness, independence earlier • More focus on prevention, early intervention	• Referrals often made after there is an issue – at time of crisis or higher risk • Little clear linkage with primary care system and family physicians before clients are in real crisis and/or need
Arrange for team assessments/intervention • E.g. Registered Dietitian and Speech-Language Pathologist at the same time for feeding • Reduces duplication and increases efficiency • Technology could possibly facilitate this process • Reduces clients having to repeat themselves – promoting a more positive client and family experience	• Often only one service is authorized due to rationing of resources • Referrals to different disciplines may occur weeks or months apart • Results in duplication and repetition of assessment processes, limited opportunities for coordinated care planning, etc.

4. Health care consumes a significant portion of the provincial budget, and these costs are growing. What **innovations and new approaches** to care delivery could be made to **maximize the value of our investment** in home and community care? Where are the **greatest opportunities for impact?**

New Approaches/Innovations
Access to the multidisciplinary team in publicly funded clinics or sites or in connection with or as part of a primary health care organization, for example for wound care – to take advantage of "teachable moments" with members of the care team accessible in real time • Could be held at existing centres – e.g. seniors centres, day programs • Provide education/health teaching, consultation • Could be very efficient, cost effective • Great need in light of decreasing OPD resources or lack of access to providers in other parts of the publicly funded system (e.g. OT, SLP) • Addresses needs of more moderate need clients • Emphasis on self-management – own role in safety, wellness, independence
(Re)implementation of restorative/treatment model of care (maintaining a consultative role where appropriate). Could be supported through the appropriate use of unregulated care providers for Occupational Therapy, Physiotherapy and Speech-Language Pathology – but need to respect regulatory requirements. CCACs need to be well informed of the regulatory model for the use of assistants. • Teaching/training by Registered Dietitians can take place for paid and unpaid caregivers re nutrition • Up front intensive service has been shown to generate benefits more efficiently
Access to a full range of services in order to address more than physical/medical risk or acute needs • Mental health services are not consistently available • Dementia care and behaviour management • Ongoing chronic disease management

5. Please comment on any **additional issue** that is not addressed in the above questions but that you feel will help the Expert Group develop its recommendations.

Housing Options – Age Friendly Environments • Communal settings could benefit some seniors in order to delay or avoid institutionalization • Equipment/modifications to support independence need to be funded to support aging in place

THANK YOU FOR YOUR INPUT

Respondent Demographics

To help us in our analysis, please provide the following information about you and/or your association:

6. Are you responding as:

	An individual *(Go to Question 7)*
x	An association representing a group or agencies/ organizations/ providers *(Go to Question 9)*
	An individual agency or organization *(Go to Question 10)*

7. How would you describe yourself? *(Please check only one response.)*

☐	Individual in need who receives care in the home or community *(Go to Question 7)*
☐	Person (e.g., family friend, neighbour) who provides unpaid care to a person in the home or community *(Go to Question 7)*
☐	Person who provides paid services (e.g., housekeeping, meals) to a person in the home or community *(Go to Question 9)*
☐	Health care professional who provides care to a person in the home or community *(Go to Question 9)*
☐	Person in Ontario interested in home and community care *(Go to Question 9)*

7. Is the person who receives the care:

☐	Under 18 years of age
☐	19 to 64 years of age
☐	65 to 74 years of age
☐	75 to 84 years of age
☐	85 years of age or older

8. Why do you or the person you care for require care *(Check as many as apply.)*

☐	New mother or newborn baby
☐	Complex medical condition
☐	Recovering from an illness or injury
☐	Chronic disease
☐	Frail and elderly
☐	Palliative
☐	Other. Please specify_____

Go to the final page.

IF YOU ARE RESPONDING AS AN ASSOCIATION REPRESENTING A GROUP OF AGENCIES/ ORGANIZATIION/ PROVIDERS (IF NOT, SKIP TO QUESTION 10):

9. What group(s) does your association represent? *(Please check as many as apply.)*

	Individuals in need who receive care in the home or community
	Persons (e.g., family friend, neighbour) who provide unpaid care to a person in the home or community
	Persons who provide paid services (e.g., housekeeping, meals) to a person in the home or community
	Health care professionals who provide care to a person in the home or community
	For profit service provider organizations
	Not-for-profit service provider organizations
	Community Care Access Centres
	Local Health Integration Networks
x	Other (please specify) **We are an Alliance of the Provincial Therapy Associations, whose members may be contracted service providers, or service providers employed by CCAC's (as front line therapists or Client Care Coordinators)**

Go to the final page.

IF YOU ARE RESPONDING AS AN INDIVIDUAL AGENCY/ORGANIZATION:

*10.*What care or services does your organization provide? *(Please check as many as apply.)*

	Community support services (e.g., assistance with activities of daily living housekeeping, meals, personal support)
	Home care (e.g., wound care, chronic disease management)
	Mental health services
	Social services
	Education
	Primary care (e.g., medical care)
	Hospital care
	Long-term care (i.e., in a long-term care home)
	End-of-life, palliative or hospice care
	Care coordination
	Funding of home and community services, system integration
	Other (please specify)

Thank you for responding to our survey. We appreciate your time and interest in this most important project.

OPTIONAL INFORMATION:

The following information is optional, and is only requested in case we wish to follow up with you for additional information or clarification on your responses. Individual respondents will not be identified.

Name of person completing the form: _Chris Linton, Chair

Association or Organization represented (if applicable): _APACTS_____

Email address: _____chris.linton@closingthegap.ca_____

Telephone: __(905) 306-0202 x3608_____