Ontario Society of Occupational Therapists

Feedback to Levels of Care Framework Discussion Paper

September 30, 2016

The Ontario Society of Occupational Therapists is pleased to provide comment on the *Levels Care Framework Discussion Paper* circulated in July 2016 which provides a draft framework to guide the development and delivery of home and community care services to ensure that Ontarians receive consistent high quality home and community care regardless of where they live and can be confident that they will receive the services they need when and where the need them.

Introduction

The Ontario Society of Occupational Therapists (OSOT) is the professional association of over 4300 occupational therapists and student occupational therapists who work across the province, across the current sectors of our health care system – primary care, acute care, rehabilitation, community care, long-term care and with clients across the lifespan. Occupational therapists (OTs) work with Ontarians who experience barriers to managing day to day living skills as result of a health issue such as illness, injury, chronic disease, mental illness, learning problems, aging. OTs work with their clients to minimize barriers, finding solutions that enable function and participation in occupations that are meaningful for them, including such occupations as self care, managing at home, school or work, engaging socially, caring for one's family and/or home and participating actively in the community in which they live.

Occupational therapists are important resources to a health care system focused on enabling people to maintain health and safe independence so as to maximize their quality of life and minimize their need for or dependence upon the health care system. OTs are also critical resources to patients and the health care system when illness, injury, mental health problems, etc. disrupt peoples' lives and ability to manage. Enabling people to restore, regain function or adapt to new functional abilities ensures that patients are able to return home from hospital, to manage with less dependence on caregivers and long-term care, to regain quality of life and engagement in their communities. As we understand the goals for and pressures on our health care system, we believe that the profession of occupational therapy has much to contribute.

Occupational therapists are well situated to add value when working in the community. Life happens at home, at school, at work…in the community, not in a hospital. The profession of occupational therapy has a longstanding history of engagement in community health care, notwithstanding access to publicly funded OT services remains critically limited. With our comments on the proposed framework we offer perspectives built upon our members' experience in the publicly funded home care programs of the past, as contracted service providers to CCACs in the present home care system and in the primary care system where OTs now work in Community Health Centres and Family Health Teams. Further, we draw upon the

insight and experience of occupational therapists working amongst community service support agencies, long-term care homes and as private practitioners serving Ontarians living at home as these perspectives lend depth to our understanding of need in the community sector.

General Comments

The Society fully supports the rationale for a Levels of Care Framework for home and community care. Our members' experience and observation underlines the expressed need to achieve more consistent, high quality services to *all* Ontarians regardless of where they live and to ensure that people can be well informed about the range of services and options available to them and how to access them when and where needed. The expressed goals that ground the proposed Framework are supported. Government has our full support to work towards achieving these objectives.

We offer the following general comments on the proposed Framework;

1. Where is the Statement of Home and Community Care Values?

The Ministry's 2015 *Roadmap to Strengthen Home and Community Care* commits to the development of a statement of shared values to guide the transformation of home and community care, with the needs of clients and their caregivers at the centre. OSOT believes this is a critical initiative and is curious and concerned that work to develop a Framework has proceeded without clear articulation of the underlying values. The goals articulated identify desired outcomes but they do not lend insight into what is deemed important by government and Ontarians to guide the "what" or "how" of home and community care. Occupational therapists believe there is an important opportunity to lay a foundation for transformational change that is grounded by values that have been generated through the proposed consultations with stakeholders. Some of our following points identify questions that relate to a lack of clear articulation of the values driving transformation of this sector.

2. Defining "Care" in a Levels of Care Framework

Without being pedantic, we draw attention to the lack of clear definition of what is meant by the term "care" in the proposed framework. Ontario's home and community care system provides a wide range of services and supports to people and their caregivers. Some of these services (e.g. personal support, nursing) fit well with a populace understanding of care, others do not. Therapy services, home safety/accessibility consultations, transportation services, etc. are clearly supports that enable people to recover after hospital discharge or live safely in their homes with

chronic disease or disability but don't fit that populace definition of "care". We raise this issue because we believe the intent is to include a broad range of community based services and supports, however, this does not necessarily come across in the document. The Functional Support Tool for example, is identified to provide guidance to appropriate levels of personal support. Without a value statement that speaks to providing services beyond personal care, we are concerned that the system could be reduced to just that.

3. Infusing a philosophy of restorative care in home and community care

Occupational therapists view Ontario's current home care system with concern as policy pressures and funding limitations have eroded reasonable commitments to a system that enables people to maintain or restore their functional capacity at the highest possible level for the longest possible time. While broad policy goals are to support more Ontarians to age at home, CCACs currently invest little in enabling people and their families to maximize and maintain strengths, abilities and independence. Solutions to needs are most often addressed by providing care. OTs would argue that we've become focused on "caring for" rather than "enabling people (including families) to care for themselves". This is evidenced in the steady decline in funding and access to therapy services. Occupational therapists, for example, are often not engaged in client care unless there is a need for equipment to enable a client to return home and/or to enable a caregiver (family or PSW) to manage care. The profession would position that now is the time to assert a fundamental shift in policy and thinking that supports attention to supporting people to maintain independence and live active lives. This drives a shift in focus from post-hospital care to pre-incident support that effectively supports living with chronic disease/disability or functional decline associated with aging. While we note that internationally, several jurisdictions (Denmark, Britain, Australia) have adopted such approaches, there is nothing in the proposed Framework that would suggest this shift in direction.

4. Addressing system needs for capacity building

Ontario needs to create increased capacity to support a growing senior population who desire to age in the community and who government wishes to see supported to age in the community with long-term care facilities as the choice of last resort. The needs of this growing population are particularly concerning in light of societal trends that actually reduce the base of traditional caregivers (more women working out of the home, family more dispersed geographically, etc.). Occupational therapists identify opportunities to build capacity through the levels of care framework by:

a. Identifying needs for services that support family and unpaid caregivers (friends, neighbours, etc) to effectively and safely manage care when they are able to assume such roles. This may include education, support groups, respite, consultation with rehab professionals (e.g. a consult with an occupational therapist to identify adaptive equipment that can ease caregiving demands or assess a client's potential to resume functional tasks with modification or adaptive devices to minimize care needs). These types of supports are critical to ensure that caregivers do not become the overwhelmed caregiver that is more likely to turn to hospital or long-term care admission or that are less likely to accept family members home again after a hospital admission.

b. Identifying the importance of educating formal caregivers to support strengths based approaches to enabling clients to perform activities of daily living to the full extent they are possible so as to minimize care needs and promote safe, independence. Piloting of the Australian model, the Home Independence Program, in several Ontario CCACs has identified that the strategy of partnering an occupational therapist (OT) with a PSW at the commencement of a care commitment can effectively minimize care needs over the longer term. By enabling the client to practice or restore capacity to manage ADL skills that are identified by the OT, the PSW promotes return to function as opposed to providing care that reinforces and promotes dependency. Ensuring that people receive only the right amount of care they need and promoting functional restoration and rehabilitation approaches, PSW resources can go farther.

c. Identifying community services and supports that benefit all residents, not just services and supports that serve people who already have needs. This strategy may lie outside of the levels of care framework but may be important to complement any framework's potential for success. In re-design of the home and community care system, attention placed, through integration with primary care and health promotion, on the development of resources/services that support people to age in place *before* they experience care or support needs (i.e. attention to strategies that benefit ALL) builds capacity by reducing need and ensuring that those people with more complex needs can be adequately served by system resources. This approach is integrated into the Special Needs Strategy's engagement of universal design for learning strategies. OTs see similar opportunity to address capacity issues through targeted attention to services with attention to supports such as accessible community transportation systems,

community accessibility, vibrant community centres/programs of education/support focused on health & wellness, home safety, chronic disease self-management, falls prevention, driving cessation, social opportunities, etc.

d. Attention to needs for increased infrastructure to support aging in place more effectively and to enable more cost-efficient models of service delivery thereby supporting system capacity. For example, increased access to supportive housing.

5. Supports for families and caregivers

For all the reasons listed above and the many underlined in the Donner report, OSOT applauds the articulated focus to serve families and caregivers as a target audience in addition to the person with care needs.

6. Linkages with Primary Health Care Sector

OSOT would assert that the underpinning values of the Levels of Care Framework should explicitly link home and community care with primary care. Strengthening clarity around consistent Levels of Care and a commitment to accessible Quality Standards should enable family physicians and interprofessional primary care teams to be better informed about their patients' care provided through the home and community care sector, however, even in the case example provided, there are limited explicit examples of how care plans are shared and monitored. Explicit relationships may be defined in Quality Standards but direction at a policy level would more effectively clarify linkages that would minimize duplication of service, promote service efficiencies and more effectively support people receiving home and community care services.

7. Commitments to supporting Ontarians with mental health support needs

Occupational therapists note that the document is silent on commitments to supports for persons living with mental illness and their families. To this point, services for persons living with mental illness have not been well supported by Ontario's home care program. There needs to be clear identification of what supports are available for persons living with mental health issues and their families and/or clear and consistent linkages with community based mental health services. The gaps identified through the development of Ontario's Mental Health and Addictions Strategy are evidenced in community care. Clients with co-morbidities including mental illness or those living with the stressful impacts of multiple chronic diseases need access to services from mental health professionals and supports.

Element 1: Levels of Care Framework

The proposed framework's quantification of care needs on a scale from light to very high reinforces the perception that the framework essentially speaks to access to personal support care or support for IADLs. This raises the following questions;

- **What care or services will the framework address?** We believe the framework needs to address a full range of services including care coordination, personal support for activities of daily living and instrumental activities of daily living, clinical services including occupational therapy, physiotherapy, speech-language pathology, social work, dietetics, etc., caregiver support and other services such as provision of equipment.

- **Where does access to professional services such as rehabilitation fit into the framework?** Some may presume that those clients with at least moderate care needs would be those seen by a rehab professional such as an occupational therapist – perhaps to offer consultation around home safety, accessibility modification, adaptive equipment, etc. Occupational therapists would suggest that an optimal time for professional intervention is in the early phases of functional decline, when rehabilitative strategies or accommodations could support restoration of function. In today's CCAC system, clients with light care needs are typically referred to the community support services sector. Regretfully, this sector has no access to professional services that may aid in assessing a client's potential for restoration of function or improved independence. When personal care is the only option offered, client independence can be compromised. OSOT would assert that consideration of rehabilitative/restorative potential needs to be addressed at lowest levels of the framework.

- **The challenge of a model that is based on level of need is that there may be a perverse incentive for clients and their families to maintain a level of need as opposed to working to minimize care needs by optimizing independence and function**. Once provided, care is difficult to take away. This is observed in our current system. The need to address the kinds of supports that family and caregivers require to manage the physical and emotional demands of caregiving and burnout is important as mentioned above. This also speaks to the need to have the goals of care provided at each level of care explicitly communicated and understood by clients and families. A consistent approach for re-assessment of needs will be required to objectively inform decisions to move to different levels of care.

- **Allowing for flexibility and individualization of care plans within each level of care.** While consistency of access to services is important, the ability for care coordinators and clients to define care plans best suited to client needs, preferences and personal goals is most desirable and best supports the goal of putting patients first.

Element 2: Functional Support Tool

OSOT supports strategies to assure more consistent access to care across the province. We understand that the Functional Support Tool would be used by care coordinators after client/family assessment identifies needs and is intended to support consistency of service/care assignment.

Element 3: Quality Standards

OSOT supports the development of Quality Standards to ensure that patients with similar clinical conditions are consistently treated using agreed upon best practices. This practice will, however, only be successful if home and community services funding supports delivery of the Quality Standard. In the absence of developed Quality Standards it will be important to consider that historical data from CCACs is only one point of reference when it comes to defining the "right" service(s) needs and intensity. We know that services have been allocated to meet the budget, not necessarily to meet needs of clients.

Element 4: Home and Community Care Assessment Policy

A formal assessment policy with the articulated goals is supported. Occupational therapists position that the importance of patient and caregiver participation cannot be understated. This input should not be limited to responding to the assessment of skills and needs; identification of patient and caregiver goals and priorities and identification of those activities that are meaningful to the client is paramount if a true *patient first* approach is embraced. Consideration of tools that effectively gather and measure outcomes on client goals are worthy of consideration. Occupational therapists are familiar with the Canadian Occupational Performance Measure (COPM) which is an individualized, client-centred outcome measure designed to capture a client's self-perception of performance in everyday living, over time. The COPM, which initiates the conversation with clients about performance issues in everyday living,

provides the basis for setting intervention goals. Multidisciplinary health care teams have also used the COPM extensively as an initial client-centred assessment. The COPM is intended for use as an outcome measure, and as such, should be administered at the beginning of services, and again at appropriate intervals thereafter. Achieving the paradigm shift to a more restorative/enabling model or focus for home and community care will require real attention to the individual's goals as well as those of their family.

Element 5: Home Care Indicators

The commitment to monitor, re-assess and further develop/improve the home and community care sector is fully supported. A commitment to include Patient Experience Indicators is in keeping with the stated goals for the Levels of Care. As noted above, we observe that there is no measure of outcome from a patient's perspective – how has the care plan supported achievement of the client's goals? The COPM, mentioned above was designed as an outcome measure for use with all clients regardless of diagnosis (Law et al, 2004) and has been validated with patients drawn from the following populations:

- Stroke
- COPD
- Pain
- Cerebral Palsy
- Traumatic Brain Injury
- Parkinson's Disease
- Arthritis
- Pediatrics
- Ankylosing Spondylitis

If the transformation of home and community care aims to place increased value on capacity building/preventative strategies, indicators that provide insight into actualization of this goal could be helpful. For example, the number of caregivers who receive education and support sessions.

Challenges to implementation of the Levels of Care Framework

Occupational therapists identify the following potential barriers or challenges to implementation of the significant changes that the Levels of Care Framework could prescribe.

- Significant change requires effective change management. Without investment in the process of change, transitions to new processes, best practices, etc. can be stressful, time-consuming and overwhelming for stakeholders, including clinicians on the front line. Respectful attention to the impacts and needs of those affected by changing policy and practices and investment to address these through the change process will influence success. Associations such as the Ontario Society of Occupational Therapists are resources to support coordinated change management efforts.

- Opportunities for more effective integration of services across primary care, home and community care and hospital sectors is exciting and offers great potential for innovation. Support and policy to incent or promote integration is needed.

- Maintenance of current managed competition contracts in the CCAC sector exacerbate inequities across regions and may be barriers to introduction of new guidelines and processes.

- Caregiver stress and burden needs to be addressed upfront to ensure that we continue to have caregivers that are willing to support their family members. Supporting caregivers *before* their loved one's functional decline reaches a point of significant strain is critical to avoid reliance on hospital or LTC Home admissions. For example, access to respite and/or short stay care options.

- Funding for community support services needs to recognize the important contributions that access to supports for instrumental activities of daily living provide to keeping people living as independently for as long as possible in their homes. Services such as snow removal, driving services, social support groups, etc. enable people to maintain healthy, engaged lifestyles to the fullest extent of their potential.

- Challenges of distance and limited resource in rural areas need to be addressed in order to achieve the commitment of equitable access to services. This may require investment in innovative technologies where upfront costs are returned over time.

- Access to a greater range of service delivery options may reduce costs and enable community dwelling longer. For example, increased access to supportive housing, attendant care, day programs.

While the Ontario Society of Occupational Therapists identifies challenges to implementation of the proposed Levels of Care Framework, we remain supportive of the goals and extend a commitment to work further with the Ministry to explore ways in which to build a home and community care system that can achieve these goals.