Submission to Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Implementation Branch

Proposed Amendments to Regulation 386/99 under the Home Care and Community Services Act, 1994 relating to the Provision of Community Services

Home Care Ontario
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Proposed Amendments to Regulation 386/99 under the Home Care and Community Services Act, 1994 relating to the Provision of Community Services

Home Care Ontario is pleased to provide comment on the government's plan to amend Regulation 386/99 under the Home Care and Community Services Act, 1994 (HCCSA) to increase the maximum amount of nursing services that Community Care Access Centres (CCACs) may allocate to service providers for client care.[1]

The increase in nursing hours available for clients with complex needs and/or in extraordinary circumstances is a welcome step in the "Roadmap to Strengthen Home and Community Care"[2].

Home Care Ontario believes that all strategies to allocate limited home care resources must be based on clinically sound evidence that considers the care needs of individual clients, broader health populations and the impact on the function of the entire health care system. While increased nursing service is important, funding is best applied when it supports outcome based care.

The Association therefore recommends that:

- Work to establish integrated care for specific populations be expedited
- InterRAI data be used to help policymakers, administrators and clinicians to improve resourcing based on outcomes achieved
- Analytical support be provided to the home care sector so that care packages can be assessed based on clinical indicators and interRAI assessments
- Service provider organizations be afforded more latitude to deliver care packages based on clinical evidence for which they are accountable
- Future government funding be linked to context, evidence and system utilization performance.

Enabling all team members to provide home care services ensures that the outcomes realized are greater than the sum of the parts – in other words, value is realized.

Background

The shift to home-based care is in large part based on the understanding that home is where patients and their families would prefer to be. In addition to improved quality of life, care at home decreases the risk of infection and increases the likelihood of ambulation and socialization – both of which are required to support recuperation.

Home care is delivered by service provider organizations (SPOs) that meet high standards of excellence, many of which are reported publicly by Health Quality Ontario.[3] Home care services

[1] Details regarding the change at Appendix 1 and retrieved from http://www.ontariocanada.com/registry/view.do?postingId=18703
[2] Ministry of Health & Long-Term Care. (2015) Retrieved from http://www.health.gov.on.ca/en/public/programs/ccac/roadmap.pdf
[3] Health Quality Ontario – See http://www.hqontario.ca/public-reporting/home-care

include nursing, personal support / homemaker, therapy (including physiotherapy, occupational therapy, speech language pathology, social work, nutrition/dietetics), medical supplies and equipment, and case management. Each interdisciplinary team member has a unique body of knowledge and scope of practice, which must be respected and leveraged in order to maximize effectiveness for client care.

The home care sector in Ontario has worked to develop a framework for care that is grounded in accountability for quality service delivery and patient outcomes. Central to this approach is the expectation of providers to be paid based on outcomes achieved for patient populations. To sustain this work providers need funding that enables evidence-based care for specific needs in within the population. When one discipline is singled out for funding, the impact on clinical outcomes and innovation is potentially compromised. Concern arises that services are not understood or valued and therefore not utilized.

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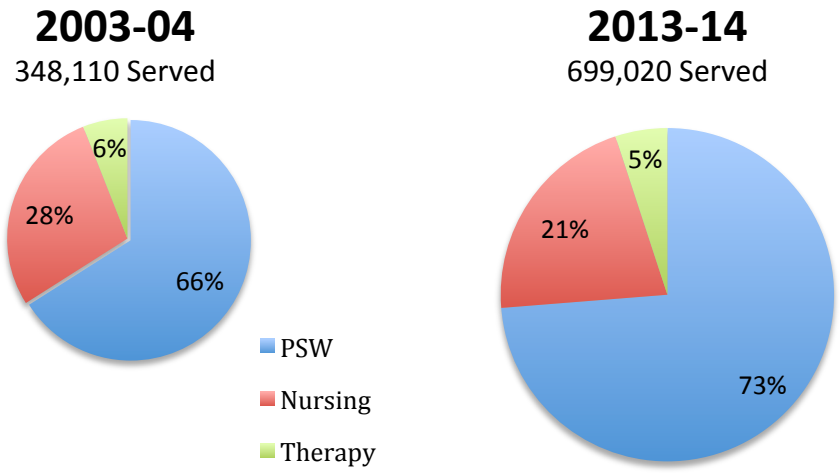
Government needs to move away from funding disciplines and move toward funding care. Funding should reflect the context, need and evidence to support the investment.

By the Numbers

In Ontario in 2013-14, 73% of care delivered by SPOs through the CCAC was Personal Support Work, 21% Nursing and 5% Therapy. It is not clear if this is the "right mix" of service. In the past 10 years[4], the number of Ontarians served by the government through the CCACs has increased 43% with personal support services increasing the most (78%).

The growth in numbers of individuals served and mix of services are reflected in the pie charts below.



[4] 2003/04 to 2013/14

Increases in home care have been an important part of the government's response to the shifting demographics and increased demand for care at home. In order to stretch funding and meet the growing demands for care, there would appear to be a reliance on the least expensive service – personal support.

Home Care Ontario has expressed concern at the lack of evidence to support this funding trend and continues to call for analysis of outcomes in both quality of care for people and system utilization. While key members of the home care team, additional supportive personal care is not a substitute for the clinical intervention delivered by highly qualified professional staff. The full array of service must be available in home care and the right provider must be able to deliver care based on patient need.

Health system success will be enabled when the focus is shifted away from segmenting the team and attributing value for the individual disciplines. Attention must be focused on setting priorities and allocating health dollars to achieve the best results of care for patients and patient populations. This shift will facilitate the adoption of strategies for care for identified populations based on agreed upon health outcomes. Home Care Ontario believes that this is how the true value of the 'health system' is defined.

interRAI

Through the employment of standardized interRAI assessment tools,[5] home care stakeholders potentially have access to massive amounts of client information that would allow data comparison for administrative decisions - including quality benchmarking, and identifying best practices both within and across organizations and health care sectors and patient populations. Algorithms, such as the MAPLe[6], serve as sound decision-support tools that can inform choices related to allocation of resources and prioritization of clients.

To date, the home care tool, RAI-HC[7], has been the exclusive responsibility of the CCAC case manager. Clinicians, clients and families report having limited information about the RAI other than to realize that their "score" may influence services.

Research has shown that decisions about the allocation of resources for care that are not based in standardized assessments and are not accompanied by decision-support algorithms that aid in the interpretation of assessment results can trigger poor outcomes for clients, provider frustration and inappropriate system utilization. Clinicians and case managers must work together using

[5] InterRAI is a collaborative network of researchers in over 30 countries committed to improving health care for persons who are elderly, frail, or disabled. The goal is to promote evidence-based clinical practice and policy decisions through the collection and interpretation of high quality data about the characteristics and outcomes of persons served across a variety of health and social services settings. http://www.interrai.org

[6] The MAPLe differentiates clients into five priority levels, based on their risk of adverse outcomes. The MAPLe algorithm is based on a broad range of clinical variables in the HC. MAPLe also predicts caregiver stress. http://www.interrai.org/section/view/?fnode=30

[7] Resident Assessment Instrument – Home Care - is a standardized, multi-dimensional assessment system for determining client needs, which includes quality indicators, client assessment protocols, outcome measurement scales and a case mix system. (Central CCAC 2009 The Value of interRAI-HC for Planning).

common assessment tools that generate sound data as the basis of clinical care decision-making, quality and funding.

Within home care there must be a commitment to sharing and using RAI-HC data in accessible and readily comprehensible formats. The team needs to know which Clinical Assessment Protocols (CAPs)[8] have been triggered so that care plans can be developed, implemented and evaluated based on the findings of the objective assessment. This process will provide the requisite evidence to support policymaking and funding.

Conclusion

Providing quality health care to Ontarians is a fundamental principle on which the government of Ontario bases health care policy development. Evidence demonstrates the value of the interdisciplinary team in the home care setting and that singular funding of a service should therefore be carefully considered in the context of system needs and client outcomes. Short-term cost savings can create unintended long-term effects on health system utilization and more importantly, quality of life for the person and their caregivers.

Home Care Ontario recognizes the value of the whole team and does not ascribe greater value to any one service. All services are important and understanding the "right mix" can be realized through evidence-based experience using a common set of tools.

About Home Care Ontario

Home Care Ontario, the voice of home care in Ontario™, is a member-based organization with a mandate to promote growth and development of the home care sector through advocacy, knowledge transfer, and member service. Home Care Ontario members include those engaged in and/or supportive of home-based health care. In Ontario, service provider organizations are responsible for providing nursing care, home support services, personal care, physiotherapy, occupational therapy, social work, dietetics, speech language therapy and medical equipment and supplies in the home to individuals of all ages. An estimated 54 million hours of publicly and privately purchased home care service is provided annually across the province.

For more information, contact:
Susan D. VanderBent, CEO
Phone: 905-543-9474
Email: sue.vanderbent@homecareontario.ca

[8] Clinical Assessment Protocols (CAPs) assist the assessor to interpret systematically all the information recorded on an instrument. CAPs help the clinician focus on key issues identified during the assessment – see http://www.interrai.org/protocols.html

Appendix 1 – Proposed Nursing Services Maximum[9]

Current State
Under the current Regulation, a CCAC cannot provide more than the lesser of the following amounts of nursing services:

1. 120 visits to or from a registered nurse (RN), registered practical nurse (RPN) or a registered nurse in the extended class (RNEC) in a 30-day period.

2. The following number of hours in a 30-day period:
    i. 184 hours of service (for services provided by RNs and/or RNECs);
    ii. 227 hours of service (for services provided by RPNs); or
    iii. 206 hours of service (for services provided by RNs and RPNs, RPNs and RNECs, or RNs, RPNs and RNECS)

Proposed Future State
Under the proposed new nursing services maximum, CCACs would be able to provide clients with complex needs the lesser of the following amounts of nursing services:

1. 150 visits to or from a RN, RPN or RNEC in a 30-day period.

2. The following number of hours in a 30-day period:
    i. 230 hours of service (for services provided by RNs and/or RNECs);
    ii. 284 hours of service (for services provided by RPNs); or
    iii. 258 hours of service (for services provided by RNs and RPNs, RPNs and RNECs, or RNs, RPNs and RNECs)

In addition, CCACs would have the discretion in extraordinary circumstances to provide more than the maximum number of visits and hours to the following clients:
i) Clients in the last stages of life;
ii) Clients currently on a waiting list for admission to a long-term care home; or
iii) Clients who require extra nursing services for a short period of time.

[9] As outlined and posted on June 2, 2015 at http://www.ontariocanada.com/registry/view.do?postingId=18703