MODERNIZING HOME CARE

The Champlain LHIN Board has identified as a priority the need to modernize home and community care. The purpose of this document is to support and stimulate discussion by the Board of Directors by providing an initial perspective on the most important aspects of the home care delivery system that need to be considered to ensure capacity to meet current and forecasted demand and expectations for home and community care. The Board together with LHIN management will also discuss whether the inventory of areas for consideration contained herein is complete and whether all the areas included meet the tests of being both relevant and important.

To stimulate discussion a number of questions are posed but posing these questions does not mean that answers have been pre-determined—they have not. By the same token, we believe that it is important to address these questions to make sure that our deliberations add up to a cohesive whole.

A CRITICAL PART OF HEALTH CARE & A STRATEGIC GOAL IN CHAMPLAIN REGION

Home and community care is crucial to being able to meet the health care needs of our 1.3 million Champlain residents and to ensuring a high quality, sustainable health care system.

- *Every day there are over 20,000 patients in our care (over 60,000 annually—at a cost $250 million)*
- *Every year patients receive 4 million home care visits made by thousands of health and allied health professionals and workers*
- *By 2038, the number of people requiring home care is expect to rise 85% (to nearly 120,000 patients per year)*
- *If home-care patients in the Champlain region were to be treated in hospitals or long-term care homes, it would cost an additional $13*0 million every year, requiring about 260 extra acute-care hospital beds, roughly 1,500 added long-term care home beds, and 100,000 more hospital emergency room visits—creating additional burdens to an already challenged system.
- *The return on home care spending is better than 4 to 1 (that is for every $1 (one) spent on home care, $4 (four) in hospital and long-term care home system costs are saved.*
- *In our most recent fiscal year we reduced annual management and administration costs by 14% to produce a saving of $1.4 million that the Province could re-invest in other direct health care services.*
- *Each of our care coordinators (a direct part of providing patient care—not 'administration') has a caseload of 120 patients—one of the highest ratio's in the province*

A strategic goal of our LHIN, as reflected in the Board approved ***Integrated Health Services Plan*** submitted to the government is to modernize home care—not because we think that home care is poor but because:

- *We are committed to improving all key elements of our health care system;*
- *We are committed to putting patients' needs and interests first; and,*
- *We recognize that in any endeavor, significant improvement can always be made.*

We have chosen to use the term 'modernizing home care' to identify, consider and, if judged appropriate, to then approve, sanction or champion a range transformative directions which have the potential, either individually or in combination or in totality, to increase the quality and efficiency of home and community care and provide easier more ready access to that care by patients and family care givers.

The importance of modernizing home care takes on special significance in the context of expected future needs as well as making sure that home and community care is aligned with other parts of the health care system as best it can and should be (e.g. with primary, acute, sub- acute, long-term and palliative care and with mental health and pediatric care).

Modernization is also important because of the legitimate expectations of patients and families for: greater predictability and advance notice for the timing of appointments; service provider access to and consideration of relevant health records; reassurance that the right medications have come home with them from hospital; being informed and asked about the next step in their care; having families involved in treatment and care plan discussions; and, knowing who to call if there are questions or issues and feeling confident someone can and will answer.

WHAT NEEDS TO BE CONSIDERED AS WE AND OTHERS STRIVE TO MODERNIZE HOME CARE

Home care is a big undertaking, especially when thought of as being the operation of an extensible hospital. In other words the beds are in peoples' homes rather than in hospitals —in our region, there are 20,000 of them thus making the LHIN one of the largest 'hospitals' albeit an extensible hospital.

Delivering home care services is inherently a complicated business made more so by a direct/indirect service delivery model. Direct in that the LHIN undertakes with its own staff the determination of the eligibility, nature and quantum of services to be provided to individuals and in some cases actually provides clinical and/or therapeutic services. Indirect in that the vast majority of services are delivered by contractors who are accountable to us and by a host of community service organizations many of which receive funding from the LHIN.

Regardless of the 'mixed delivery model' the LHIN is accountable for the timeliness and quality of services provided directly and indirectly and the efficiency, probity and effective use of the overall financial resources entrusted by the province to the LHIN for home care.

There are many questions and issues that attend our home care mission and services. While there is little doubt that we are 'doing the right thing' —could we envision a robust health care system without a home care component? (See cost/benefit information provided in the previous section)—how well we are doing it and how we could do it better remain valid questions to consider.

Within the ambit of this this overall question, what will anyone seeking to modernize home care need to consider in order to meet current and future demand and expectations for both efficiency and quality? The following, captured in two groups: people issues and systemic issues, are 'top of mind' in our modernization consideration.

UNLOCKING THE VALUE OF PEOPLE

Care Coordinators

Through their assessment, intake, service allocation, organization, monitoring, communication and discharge activities, care coordinators are front and center in providing appropriate, quality care for home care and prospective home care patients.

Care coordination is not an 'administrative function'. It is a critical and embedded first and continuing step in providing care–analogous to what a family physician does in prescribing medication or treatment.

Our submitted Integrated Health Services Plan embeds the view that care coordinators are uniquely positioned to potentially add even greater value than they do now. This by potentially being assigned a more comprehensive role for the organization of home health and community care services and the alignment of these services with other elements of the health care system
(e.g. primary care).

Personal Support Workers

It is in providing personal support services that we face one of our biggest accessibility challenges (and in some cases, service delivery reliability challenges). The underlying cause of the problem most frequently cited has been an apprehended shortage of personal support workers – to wit numerous reasons have been ascribed.

Recent analysis in our LHIN acknowledges that there may be an overall shortage of personal support workers in the system but that an equally great or greater underlying problem may be how personal support workers are organized and deployed by contractors—in short, primarily a productivity problem rather than an overall workforce size problem.

Many factors will be involved in addressing the productivity question, not the least of which is that personal support workers are employed by contractors who remunerate, organize, oversee and manage their work. Issues of compensation including what work is paid for and the basic model for workloads, scheduling and point of service deployment locations are all involved.

What stance should the LHIN take—is this exclusively a service contractor problem or is it ours too? What do we expect could be achieved by way of greater productivity? Through what vehicles? What obstacles would attend?

Family Care Givers

We cannot underestimate the large part that family care givers have in our home care system. It may not be an exaggeration to say that without them the sustainability of our home care system might well be called into question. What would be the implications for us if the overall level of family care giver support declines in the future, especially as the population ages? What actions can and should we take to nurture and protect the quantum and quality of family care? If we take these actions what should our expectations be in both quality and economic terms? What investments would be required?

UNLOCKING VALUE FROM DELIVERY APPROACHES, SYSTEMS AND INSTRUMENTS

Care Coordination —Point of Delivery.

Care coordination is for the most part a LHIN centric function performed by LHIN staff located either at headquarters, at our satellite offices and in some cases by our staff situated on the premises of health service provides (e.g. hospitals).

What opportunities should be considered in which the value of our highly trained and capable care coordination staff is more highly leveraged? For example, should our care coordination activity be the same for all patient complexity levels and circumstances or might it be possible, with a view towards lightening the load for our staff, to stratify patients and assign care coordination for appropriate groups of patients differently How would the necessary accountability for quality and for resource allocation, financial management and policy compliance be maintained? What should our expectations be in both quality and economic terms for any change that might take place? What investments would be required? What new authority would be required?

The same questions could be asked relative to sub-regional imperatives and the notion of locating care coordination at the point of primary care. What is a practicable role for family physicians? How can it be best aligned with the home care services provided?

And Related to the Above—Discharge Practices

Some 40% of all referrals to home care from hospitals are 'same day' making timely actual discharge from the hospital more difficult and in some cases impossible to achieve at a point at which the patient should really be leaving the hospital. (This area has been cited as a major opportunity for innovation by Dr. Devlin in his recent speeches.) What opportunities do we have to correct this problem with a view towards befitting patients by timelier intake to home care and befitting acute care facilities by reducing ALC occurrence?

Service Contractor— Contract Models

For the most part we purchase '**units of service'** from our contractors. Apart from introducing a bias towards 'what we do and how long it takes us to do it' rather than 'what outcomes did we achieve for the patient' this approach inherently poses a greater budgetary control challenge and means that financial risk resides with the LHIN and not with its contractors.

An alternative way of doing business is to 'pay for **outcomes'**. Is this a model that has been deployed elsewhere? With what results? If movement towards this type of arrangement takes place what should our expectations be in both quality and economic terms? What would it take to move in this direction?

Service Contractor Competitiveness

Contractors currently have the benefit of contracts with LHINs which, at the prerogative of the government, have not been the subject of competitive tendering for a considerable number of years. What assumptions should be made about potential efficiency enhancements either through reduced costs or increased outputs were these contracts to be competitively tendered? (As a percent of cost or output.)

Quality Oversight and Contractor Performance/Compliance

In our two most recent previous quarterly reports we reported on instances in which contracted service providers were unable to send a health care worker to attend a patient as previously scheduled. Occurrences of missed visits diminish the quality of care. They can lead to poorer patient outcomes and experience and potentially put patient safety at risk. Within the ambit of our contractual prerogatives management has reassigned a portion of the case volume held by a contractor with significantly below par performance. The availability of other suppliers constrains the extent to which such reallocation can take place. Public reporting by the LHIN has reflected the LHIN's belief that transparency is important. All of this begs the question of whether our contracting framework and process create an unduly high level of immitigable risk when performance failures on the part of a contractor or service provider take place. If the answer is yes, what would be desirable and what must we do to get ourselves to a better position?

System Complexity

Home and community care is a system inhabited by well over 130 organizations who deliver diverse and often interdependent services which bear on home care and other elements of the health care system. The LHIN funds these organizations in whole or in part—many as a legacy inheritance from the province when the LHIN's were created. As such, the system is complex. The organizations who are part of our delivery universe are also diverse in their size and (often related to size) in their management and governance capacity. In cases this has meant that the LHIN has had to deal with deficient service provider performance which, at least in part, is attributable to management and governance capacity. While some organizations are small they nevertheless deliver important services that affect a well performing system as a whole. A question for consideration is whether there are opportunities to streamline the system by looking to mergers or service reallocations.

And Related to the Above—System Navigation

In a complex health care system ease of navigation through the system by patients is a crucial imperative to both relieve the burden on patients and families but also to make sure that patients can access the right care, at the right time and in the right place. Currently, many of our service providers operate, to various extents, their own navigation systems with the potential for patients and families to get caught in cascading navigation systems.

We should consider it our responsibility to ensure that the system can not only be navigated easily but also that patients and their families have an appropriate level of navigation support.

The first questions are whether the LHIN should be the direct system navigation provider (a role we partially carry out now)? And, what constitutes an appropriate level of support? For example—web based information system?; call centre to reference patients to resources?; partial service call centre with staff undertaking the search for patients?; full service call centre with staff undertaking the search for patients and undertaking needed bookings/service acquisition on behalf of patients? Something else?