ONTARIO PHYSIOTHERAPY ASSOCIATION

September 30, 2016

Ministry of Health and Long-Term Care
Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Submitted by email: levelsofcare@ontario.ca

RE: Levels of Care Framework Discussion Paper

Dear Sir/Madam,

The Ontario Physiotherapy Association (OPA) is the Ontario branch of the Canadian Physiotherapy Association and represents more than 6000 member physiotherapists, physiotherapist assistants and students working and living in Ontario.

OPA was pleased to participate in the July stakeholder workshop in consultation for the proposed framework laid out in the *Levels of Care Framework* discussion paper. We also appreciate this further opportunity to provide comment and thoughts on the framework.

Physiotherapy services are an integral component of home and community care for patients and families across the province. Physiotherapists work to provide high-quality care to patients and families in every sector of the health care system. Through funding reform and scope of practice changes, the profession has also demonstrated an ability not only to support, but to thrive and excel, in innovative service delivery models. We encourage the Ministry to leverage the physiotherapy profession as valuable and well-positioned partners in achieving the key objectives of this proposal.

We would like to offer the thoughts and perspectives below in response to the Ministry's invitation to provide comment on the Levels of Care Framework.

EQUITABLE CARE FOR ONTARIANS

We commend former Minister Deb Matthews, Minister Hoskins and the Ministry of Health and Long-Term Care for their work towards ensuring that Ontarians have access to the care that they need, when they need it, no matter where they live in the province. We believe that setting provincial standards and expectations for care, as has been outlined as an objective of the

framework, will help to promote consistency in care for people across Ontario, as well as collaboration among LHINs.

The diversity of regional characteristics that often contribute to the current variations in home care delivery, such as geography and existing community assets and resources, must be carefully considered in aligning funding, structures, and reporting with provincial standards for care. Particularly, rural and remote regions will require innovative approaches and thoughtful investment to ensure service delivery models are responsive to community needs and context.

REHABILITATION

Though the Levels of Care framework describes care as it relates to nursing and personal support services, rehabilitation and the potential of patients to achieve rehabilitation goals to improve function and independence for care needs are markedly absent from the document. This gap in the proposed framework poses risks that in moving forward we will miss vital opportunities to achieve optimal health outcomes for the people of Ontario, to decrease levels of care needs and to improve the sustainability of the health system through decreased downstream costs.

Timely rehabilitation is critical in preventing or delaying decline in patients' health status and in maximizing potential recovery. By stratifying individuals based on their current physical state rather than by their potential for rehabilitation, people may be precluded from accessing necessary or sufficient services for recovery and the system may miss critical opportunities for cost effective intervention. Investing resources in patients with potential for rehabilitation, would allow the levels of care framework to ensure patients get the care they need and would help to mitigate the need for higher levels of care required if a patient's health is allowed to decline. A need for early home care rehabilitation may be even more pronounced in rural settings where there can be additional barriers such as lengthy travel distances.

Access to rehabilitation services must be included at all levels of the framework to ensure that a level of care does not become a definition of individual patients, but represents only their current health status and a starting point from which to improve health outcomes.

CHANGING PATIENT NEEDS

A patient's health status, treatment or recovery is dynamic and influenced by a number of complex and interrelated factors. Though the discussion paper does touch on the idea of reassessment, there is a need for a more thorough exploration of the mechanisms that would allow a reassessment to be triggered by a patient, family or care provider. It is imperative that the model be nimble enough to identify and respond to the changing needs of patients and families; all those involved in care must have a clear understanding of how this flexibility will be achieved.

To facilitate an understanding of how patients will move between levels of care, it may be valuable to develop additional theoretical case studies of patient and family experiences with services under the proposed framework, in addition to the story of Ms. Lee.

As with most stepwise frameworks it is important to guard against perceptions that designation in one level is preferable or more beneficial than designation in another level.

EVALUATION

Monitoring and evaluation of the new levels of care framework must shine light on all areas and services of community care. The 11 Home Care indicators currently reported by Health Quality Ontario are not equally applicable or relevant across professions or services. The ability to measure the success and value of all components of patient care is vital to developing a comprehensive understanding of the system as a whole. We recommend the introduction of additional indicators to reflect the role of rehabilitation in home and community care.

This comprehensive evaluation will also be important in providing a foundation for provincial standards of practice. In establishing any evidence-based guidelines, there is a risk that evidence best reflects what is most commonly studied, and is less robust around innovative or under-studied practices and services. Developing and implementing indicators that collect information on the spectrum of services provided in home and community care will help to establish a foundation for provincial standards for practice.

Two points raised in our submission to the Patients First Proposal remain relevant in discussions of the proposed Levels of Care framework:

- TRANSITION PLANNING: Transformational changes to the delivery of home and community care require careful transition planning to reduce the risk of destabilization for patients. We trust that a transition plan will be developed in close consultation with patients, care givers and service providers to ensure patients experience seamless care throughout this transition. OPA would be pleased to assist in this critical planning process.

- PROFESSIONALS AND TEAMS WORKING TO THEIR FULL POTENTIAL: Realizing the full potential of home and community resources will require the ability of each member of the team to bring their full scope of practice, skills and capabilities to care planning and delivery. Doing so will strengthen home care, maximize the efficient use of provider time and health care resources, reduce redundancy in the system and improve timely access to diagnosis and treatment.

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Finally, we encourage the Ministry to review and engage with the valuable work being done by the Rehab Care Alliance (RCA) to help inform these important changes in the delivery of home and community care.

We thank you again for the opportunity to participate in this important discussion. OPA stands ready to offer our assistance in this transformative process.

Respectfully Submitted,

Dorianne Sauvé
Chief Executive Officer