Submission to the Standing Committee on the Legislative Assembly

Bill 175 – Connecting People to Home and Community Care Act, 2020

June 17, 2020

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Introduction and overview

Thank you for the opportunity to provide a written submission to the Standing Committee on the Legislative Assembly on *Bill 175, Connecting People to Home and Community Care Act, 2020*.

Prior to the current COVID-19 pandemic, the Ontario government was undertaking major transformations across the healthcare system to build stronger, more integrated care for Ontarians. The advent of Ontario Health Teams (OHT) to deliver more flexible, innovative models of home and community care was part of that restructuring and is supported by AFHTO and its members. For too long, patients and their families have experienced fragmentation as they fall through the cracks of our multi-faceted and siloed health and social systems of care. The intent of this Bill – to help create a system that is seamless and integrated – is something that AFHTO and its members in primary care have been advocating for years.

AFHTO would like to provide three recommendations regarding this legislation and the proposed regulations that would follow pending its passage.

1. Delay the passage of *Bill 175, Connecting People to Home and Community Care Act, 2020*

Like the rest of the world, Ontario is still in the midst of the COVID-19 pandemic and there are a lot of lessons to be learned from the provincial response. Out of fear that the number of patients presenting with COVID-19 would overwhelm the acute hospitals, people were told to stay at home and care that was typically provided in-person in primary and community care went virtual within 48 hours. Volumes for home care supports, including nursing, PSW and OT/PT care, were reduced and patients who were essentially listed as needing alternative levels of care (ALC) were effectively decanted from the hospitals and into long-term care and nursing homes. Instead of supporting people in the safety of their homes, they were exposed to high rates of COVID-19 in these congregate settings that have shown us that we are not patient-centred when it comes to caring for our older adults and frail seniors. It has also shown that the people who work in these settings, primarily PSWs, are precariously paid and overworked. Work needs to be done to ensure pay equity and to support people who are working with the most vulnerable.

The provincial government has announced that they will launch a commission into long-term care (LTC) in the fall and Ontario's ombudsman has also launched an investigation into the province's pandemic response of LTC. No doubt one of the findings in both the commission and the investigation will make reference to the transfer of the ALC patients into the congregate settings instead of into their loved ones' homes with the necessary home and community care supports. To pass legislation without learning first about the response efforts during the pandemic with this patient population seems short-sighted, as those lessons could help redefine how we can provide care differently in people's homes and in their communities.

Recommendation #1:
Delay the passage of Bill 175, Connecting People to Home and Community Care Act, 2020 until the findings of the LTC commission and investigation are completed and the challenges to the pandemic response are detailed, including how care was or was not provided in people's homes or in the community.

2. Embed care coordination in primary care

Bill 175 and its proposed regulations set in motion the timeline for winding down the Local Health Integration Networks (LHINs) in Ontario, with a transitional period in which the remaining home and community care functions in the LHINs will be rebranded and/or divested.

City of Lakes FHT in Sudbury identified that physicians and interprofessional healthcare providers (IHP) were experiencing difficulties with referrals and patient support. It was time consuming to reach the care coordinator, there was no consistency in whom the coordinator would be, FHT providers never knew the status of their patients vis-à-vis CCAC care, and it was generally felt that patients were "falling through the cracks." Providers were frustrated and worried about their patients, particularly the frail and elderly.
The former CCAC agreed to a pilot project and allocated a part-time care coordinator to work with the FHT. Now instead of faxing referrals and phoning, the process has changed to a face-to-face collaborative working relationship.

Both patients and providers are enthusiastic about the role of care coordinators in the FHT: patient care has improved; there is improved consistency of care; care coordinators have ready access to physicians and nurse practitioners; care coordinators sometimes do joint home visits with physicians and nurse practitioners, which reduces the burden on the patient of having several visits from different providers; communication breakdowns have largely been eliminated; and, most importantly, collaboration has improved, allowing for a better patient experience.

In the proposed regulations, care coordinator functions would be provided by Health Service Providers (HSPs) as defined in the *Connecting Care Act, 2019*. This definition includes the newly formed Ontario Health Teams (OHTs) and public hospitals. As an HSP, it would also include organized interprofessional team-based primary care.

Primary care is an anchor for patients and families, and it is often the first contact or entry point into the healthcare system for all new needs and problems. These are the healthcare providers who know the patients and their families the best. With well-coordinated, integrated primary care at the local level, patients will be less likely to fall through the cracks as there will be more seamless transitions of care through the system.

Comprehensive care coordination is a dimension of quality primary care that is patient-centered and leads to effective and more seamless transitions between settings and among providers. Effective care coordination by a team of providers reduces duplication, increases quality of care, facilitates access, and contributes to better value by reducing costs. It ensures continuity of care for patients regardless of setting, including home, community, hospital, long-term care facility or with their primary care team. To be effective, care coordination should be embedded in primary care.

We know that home and community care coordination services provided through the former Community Care Access Centres were episodic – about 60% followed from a hospitalization, which missed the opportunity to keep people out of hospital in the first place[i]. With the CCACs dissolved and the care coordinators placed into the current Ontario Health regional structures, communication back to primary care providers remains poor. Direct service delivery also put the regions in a conflict of interest position, hampering their ability to be objective in their primary role of health system planning.

Care co-ordination in primary care has the potential to significantly:

- Reduce the duplication and role conflict that currently exists in our health system; and

- Improve patient outcomes through much greater continuity and coordination of person-centred care.

The aspiration of Ontario Health Teams is to see a healthcare system that is truly integrated, one where patients do not have to move from one part of the system to another to get their care. Given that OHTs are a non-entity (i.e. they are not incorporated or an employer) and are currently voluntary in nature, moving these positions into primary care will allow for lower costs and better patient outcomes. Embedding care coordination in primary care will help enable the integration agenda. It will allow for seamless transitions of care and a one-point 'hub' or 'home' for a patient's care journey – the Patient Medical Home.

Recommendation #2:
We recommend the relationship between primary care and home and community care be strengthened by transitioning the function and associated resources of care coordination to primary care. This will bring greater efficiency and patient-centredness to care. Care will be integrated, allowing for seamless transitions of care for patients. It will reduce duplication and inefficiencies in the care coordination process and allow for more flexibility and integration in care planning. Patients will move through the system and providers with a single care plan, and outcomes will improve due to greater continuity and coordination of person-centred care.

3. Supporting the patient's journey through the health and social system with one patient record

In the proposed regulations that would follow the passage of this Act, it is noted that *"Health Services Providers would be responsible for care coordination – whether they are part of an Ontario Health Team or not – and would have the flexibility to assign care coordination functions to contracted providers or, through mutual agreement, to partner organizations with the goal of improving system navigation, reducing transitions for clients and eliminating duplication in assessment and care planning."*

While the level and extent differ over the course of the patient's journey through the healthcare system, everyone needs care coordination. However, there is a sizable gap between care coordination that is needed and what is currently in place. The proposed changes do not fully address that gap.

To help lessen the gap and to ensure seamless transitions of care, a critical component is that care coordinators/system navigators be embedded in their primary care setting. As an enabler for effective care coordination, the person who is coordinating the care should be a member of a team and a system navigator who creates linkages in the community with other care providers and supports a patient's journey through both the health and social systems.

Teams work with shared electronic medical records (EMR). Data and information systems that enable care and system coordination, performance metrics, reporting, and research are essential. With care still often delivered in silos, patients have to repeat stories over and over again. Some stories fall through the cracks as records are not appropriately shared across the system. Everything that is not tracked and communicated in a shared EMR that is relevant to the patient's health and wellbeing can weaken the overall quality of care that the patient receives. It is imperative that there be one patient electronic record and that the care coordinator be supported in inputting their clinical and service delivery notes into that one record.

A solid communication mechanism that can relay accurate information in a timely way is essential to high-quality care. Removing the middleman from the patient's health care delivery and enabling home care to be contracted by the primary care team and its outcomes tracked in the team's shared EMR will help all providers deliver the best, most accurate, high-quality care.

Several of the proposed care coordination functions are a step in the right direction, such as the care plan being developed in partnership with the patient and/or the patient's caregiver. Patient engagement is crucial as they are the experts for their own lives and must be involved in goal settings and care plans. However, a critical piece that is missing is the key role of care coordination: it must be less an administrative role and more about a team, with a care coordination lead, that addresses care and system navigations and supports a patient's entire journey through the health and social systems.

The Central Lambton FHT was the first in its region to embed a clinical care coordinator in the team. The care coordinator has worked with healthcare providers to help patients who are in and out of hospital deal with multiple comorbidities, and to help those who are struggling to manage their health. Physicians regularly speak with the care coordinator about their concerns and goals for patients, so they can ensure that the highest-quality, patient-centred care is delivered; ensure the patients know they are not on their own; and reduce unnecessary emergency room visits. The successful model is now being spread across the region.

"Sometimes you don't really know what you can do with respect to a patient need or what resources are available and from that perspective I would talk to Christy (care coordinator) and say this is the problem. The reason physicians are so appreciative is now we are able to extend patient care that's of high quality to when the patient actually needs that care. Patients are getting a superior quality of care," says Dr. Enoch Daniel, a family physician at Central Lambton FHT.

In addition, the role should not only support system navigation between the health and social systems, but it should include important initiatives like social prescribing to help address social isolation, as well as providing housing and income support, which are important to support and expand. The COVID-19 pandemic has highlighted that the most vulnerable in our population are exposed to the most risk, and what they need help with are the social determinants of health. They need someone who can support them through the very complex mazes of the health and social systems of care.

Care coordination and system navigation is a function of primary care and should be foundational in OHTs as they continue to develop.

Recommendation #3:
The role of a care coordinator needs to be less administrative in nature and more systems related. What is critical is care coordination as a function and a role that will support the patient through the complex health and social systems. That individual needs to be a member of a team who works with the patient and the team as a system navigator for both health and social care, using the same electronic medical record to ensure one fulsome patient story.

Conclusion

AFHTO is pleased to see the government's commitment towards truly integrated patient-centred care. Healthcare providers in interprofessional team-based primary care have been working in integrated

systems of care for years, but have felt that there was still fragmentation in the care they were able to provide because of the disconnect between the silos of care – from acute care to home care.

Primary care is the entry point to the health system and for many patients in the province, the relationship they have with their family physician or nurse practitioner is everlasting and built on trust. A truly effective, high-quality healthcare system needs to be coordinated and integrated and foundationally built in primary care, which will ensure we are delivering a sustainable health system for the future. And to reach the vision of the Patient Medical Neighbourhood, home and community care needs to be integrated and embedded into the foundational primary care system.

Taking a step back and learning from the patient and caregiver experiences through the COVID-19 pandemic (emotional, social, financial) will be very important to deliver on a truly patient-centered, newly imagined home and community care sector, so we encourage the government to delay the passage of Bill 175 until there has been time given to reflect and learn.

However, with or without a pause, we look forward to continuing to work with the government during the journey to implement this important legislation and to create a modernized home and community care system that is focused around the patient and caregiver, foundationally based in primary care.

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[i] North East LHIN (2011). LHINfo Minute. As quoted in Enhancing Community Care for Ontarians, ECCO 2.0, Registered Nurses Association of Ontario, April 2014.

AFHTO is a not-for-profit association that provides leadership to promote high-quality, comprehensive, well-integrated interprofessional primary care for the benefit of all Ontarians. It is the advocate and resource to support the spread of knowledge and best practice among 193 teams, including family health teams, nurse practitioner-led clinics, and other interprofessional models. These teams provide comprehensive primary care to over 3.5 million people in over 200 communities across Ontario. Collectively, our membership is made up of over 5,000 frontline healthcare providers and provide care for 1 in 4 Ontarians.