AFHTO and OCFP Response to Proposed Home and Community Care Regulations Related to *the Connecting People to Home and Community Care Act, 2020*

Introduction

The Association of Family Health Teams of Ontario (AFHTO) and the Ontario College of Family Physicians (OCFP) are pleased to provide a joint submission to the Ministry of Health on the proposed new regulations under the *Connecting Care Act, 2019*, pending passage of the *Connecting People to Home and Community Care Act, 2020*.

AFHTO represents the majority of primary healthcare teams across Ontario, and the OCFP represents 15,000+ Ontario family physicians. Together we support the overarching objective of the *Connecting People to Home and Community Care Act, 2020.* We share the vision of Ontario Health Teams ultimately delivering more flexible, innovative and integrated home and community care, with care providers working more collaboratively across sectors to deliver that care. Creating a system that is seamless and integrated is something that AFHTO and OCFP have been advocating for years.

To achieve a fully connected and integrated health system, we look to the Patient's Medical Home (PMH) and the Patient's Medical Neighbourhood (PMN) as the evidence-based guiding framework. Ontario and other jurisdictions look to it as well in an effort to address health system challenges. In a PMH/PMN, patients can easily access care throughout every stage of their life – that care, anchored by their family doctor or nurse practitioner, is seamlessly integrated with other services in the healthcare system, including home and community care. It is well documented that healthcare systems built on a strong primary care foundation, anchored in the PMH/PMN principles, improve patient experience, health outcomes and provider satisfaction, and lead to fewer unnecessary hospitalizations.[i,ii]

A key component of the PMH/PMN is continuity of care, in which the patient and their physician or nurse practitioner-led care team are cooperatively involved in ongoing healthcare management, The evidence is clear: maintaining continuity of care between patients and their MRP leads to improved patient satisfaction, reduced system costs, reduced hospital admissions and lower mortality.[iii] Enabling and maintaining continuity care for patients receiving care in their homes is essential for safe, efficient and effective home and community care.

And yet, as documented by the *2015 Commonwealth Fund International Health Policy Survey of Primary Care Doctors*[iv], internationally, Ontario has one of the lowest reported percentages of physicians communicating with home care and community services. Less than a third of family physicians in Ontario say they, or other personnel in their practice, routinely communicate with their patient's case manager or home care provider. Only slightly more than a third of Ontario family physicians say it is easy, or very easy, to coordinate their patients' care with social services or other community providers.

Hence, central to successfully connecting home and community care and primary care is to remove the current "red tape" and barriers that erode continuity of care for patients. This can be achieved by enabling direct links between the patient's MRP (FP or NP) with the home care provider to collaborate on the patient care needs. Home care is essentially primary care in the home, and strengthened connections will better enable and reflect that reality.

We are also mindful that there are, and will continue to be, many lessons to be learned from the provincial response to the COVID-19 pandemic, including the severe consequences it had on the home, community, and long-term care sectors. Consideration should be given to delaying enforcement of regulations until the findings of the Long-Term Care (LTC) commission and the investigation of the Ontario Ombudsman into the province's pandemic response are completed. The challenges to the pandemic response should be detailed and understood before significant changes are made, including how care was or was not supported or provided in people's homes.

For instance, no doubt one of the findings in both the LTC commission and the investigation will refer to the transfer of the ALC patients into the congregate settings instead of into their loved ones' homes with the necessary home care supports. To pass legislation without learning what was done during the pandemic with this patient population seems premature as those lessons could help redefine how we can provide care differently in people's homes.

With or without pause, we appreciate this consultation on the proposed regulations. AFHTO and OCFP are pleased to provide our input below on areas that we support, shared areas of concern, and where further clarification is warranted.

Finally, our response coincides with the newly-released report by the Canadian Institute for Health Information (CIHI) on Canadians' access of home and community care services.[v] A major finding is that 1-in-9 newly-admitted residents in long-term care homes potentially could have been cared for at home. The CIHI report cites the following barriers to remaining at home: difficulty navigating the healthcare system; limited eligibility of funded services; inflexibility of .services to the changing needs/condition of the patients; lack of access to non-medical needs such as emotional and social supports; and need for better integration and coordination of care across healthcare sectors.

We concur with the CIHI findings, and believe that our recommendations below will address the barriers identified in this timely report, and ultimately help Ontarians remain in their homes for as long as possible.

Specific Feedback on the Proposed Regulations

Changes we support

- **Service Maximums**

We support not including service maximums. This will help patients stay in their home and in their community with greater support, reducing the patient's chance to be hospitalized, which in turn could reduce overall health system burden/costs.

The patient's MRP knows them best and is in the best position to provide the insight that can help in determining needed home care. Approximately 80% to 90% of a person's health and wellbeing is determined by factors outside of the mainstream health system, and the pandemic has exacerbated some of these social determinants of health among the most vulnerable people in our province. Their needs are critical to address and can be supported through means such as homemaking and activities of daily living.

- **Bill of Rights and Complaints**

We support the inclusion of a Bill of Rights for home and community care patients, and the proposed requirements for Health Service Providers to establish a process for reviewing complaints made by home and community care patients with respect to services provided.

As a best practice, patient and caregiver co-design could be a mandatory principle of the OHT if there is the intention of allowing OHTs to determine how home care will be delivered. It should also include a mechanism for patient and caregiver feedback to all providers in the circle of care within the OHT.

- **Scope of Services**

We support distinguishing "home care services" from "community care services" to minimize confusion.

We are also pleased to see the list of services has been expanded to include those that were previously absent, such as personal support services, functions related to supplies and equipment, and the four new community care services (i.e. Aphasia services, Pain and symptom management, Diabetes education and Psychological services for persons with Acquired Brain Injuries). The expansion of services will better support home care patients' increasing complexities and co-morbidities.

We would like to note that expanding scope of services is only one factor in ensuring that no patient in Ontario who requires home care is left behind. Equally important to expanding scope of services, is re-examining Ontarians' ***eligibility to receive*** these services – see "Eligibility of Services" below.

- **Location of Services: Residential congregate care settings**

We support the need for greater oversight over home and community care that is increasingly being provided in residential congregate care settings, including a governance for their funding and oversight. We also look forward to the Ministry's planned engagement with the public,

patients, caregivers, and health system partners to develop each model and outline them in regulations – our collective members would be pleased to lend their insights.

Areas of concern and key omissions

- **Eligibility of Services**

The proposed increased flexibility for the eligibility criteria for pharmacy and physiotherapy services is a step in the right direction. We wish to reinforce, however, that many patients who can significantly benefit from home and community services continue to be denied these vital services.

The majority of home and community care coordination services provided through the former Community Care Access Centres were episodic – about 60% followed from a hospitalization[vi]. This continues to be the case today. Prioritization currently seems to be on short-term home care that is focused on post discharge from hospital or palliative and wound care, and less on other vulnerable patients needing home care such as the frail elderly or those with complex chronic conditions including mental health and addictions.

According to the new CIHI report, publicly funded home care does not cover all costs associated with caring for someone at home; some families experience significant out-of-pocket expenses. This poses a major financial barrier for many Canadian patients and their families, and a key reason for premature admission to long-term care. The report also stated that those living in rural and remote communities faced higher travel costs for medical appointments and limited availability of home care services and supports.

The lack of available home care for the above patients risks deteriorating their conditions further which, in turn, may lead to preventable emergency department use and/or hospitalization. This critical gap in care will only continue to grow given the increase in number of people living with multiple comorbidities, and who are living longer – this population requires ongoing support to manage their health in their homes and to avoid unnecessary and expensive hospital care. Thus, in examining the availability and eligibility of home care services, the Ministry should ensure that patients who have been historically denied services be ultimately connected to home and community services.

Furthermore, the Ministry should ensure that home and community care service providers enable the patient's MRP and their primary care team to easily access information about the availability, wait times, eligibility, and types/range of home care services provided in their community.

Finally, we advise that the above recommendations be applied to all those providing home and community care services, so that all patients in Ontario are supported, not solely those that are part of Ontario Health Teams.

- **Method of Delivery**

We support the proposal to continue allowing home and community care services to be delivered in-person or virtually using electronic means, if appropriate based on the assessed needs and preferences of the patient. Additional policy and implementation supports will be required to maintain optimal use of virtual care by both healthcare providers as well as their patients and caregivers.

Primary care rapidly adopted virtual care to continue caring for their patients during the COVID-19 pandemic. Leveraging the gains as well as issues identified from this experience, we recommend the following for sustaining optimal use of virtual care:

- Expanded access and choices of approved virtual care platforms, beyond OTN, that are affordable and user-friendly.
- New virtual platforms should integrate effortlessly with office workflows and booking systems.
- Virtual platforms in home and community care should be seamlessly integrated with primary care.
- Virtual codes should enable more nuanced visits; patients receiving home care often require multi-issue office visits, complex chronic disease management, among others – these are not currently reflected in the fee schedules.

To enable virtual care in the home, patients and their caregivers must be digitally empowered. Many patients receiving care in their homes have unique challenges with video conferencing, emailing, printing, etc. The is especially relevant for those living in rural, remote, or low-income areas, which may have minimal access to basic technology, such as high-speed internet or even phone connectivity. Left unaddressed, greater inequity between those who are digitally fluent/privileged and those who require further assistance/supports can ensue.

Leveraging and scaling digital health – in all its forms – must not lose an equity-based lens and should be accompanied by easy-to-access, user-friendly, 24/7 digital and IT support for patients and their caregivers.

- **Care Coordination Function**

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 their caregiver. Patient engagement is crucial as they are the experts of their own lives and must be involved in goal settings and care plans. However, having a care plan is only one step in providing quality patient care.

We see care coordinators as something more than just brokers of care services. They often assist patients in their navigation of the current system and together with physicians, are often tireless advocates for their patients' needs. Effectively advancing care of patients in their homes and communities involves going beyond administrative tasks to having a dedicated team of interprofessional healthcare providers who are working seamlessly together towards improving the patient's outcomes.

AFHTO and OCFP propose the following recommendations as it relates to care coordination:

- First, further clarify and define the essence of care coordination in the proposed regulations. As noted above, the functions of care coordination must be less about the administrative role and more about what they aim to achieve: providing wrap-around care and system navigation support for the patient's entire journey through the health and social systems. Care coordination functions within OHTs should encompass both coordination of care ("improving transitions") as well as system navigation for patients ("better connections"). This will help support continuity and follow up of patients' holistic and complex needs, including but not limited to: physiotherapy, rehabilitation, mental

health and addictions, home care, community supports (i.e. Meals on Wheels) and other needs related to the social determinants of health (e.g., income and housing supports).

- Second, for optimal results and to strengthen integration where most care happens, embed care coordination in primary care. This leverages the fact that family physicians and nurse practitioners are the MRPs for their patients' needs and problems, providing clinical evidence-based assessment and treatment recommendations. Furthermore, having care coordination in primary care has the potential to significantly reduce the duplication and improve clarity of roles that currently exists in our health system. Thus, we continue to urge the Ministry to leverage the vital role of the 4000+ care coordinators (funded through the LHINs) into supporting care coordination and system navigation and embed care coordination in primary care.

- Third, we need home and community care providers to connect with the patient's MRP, which, in turn, supports continuity of care for patients. We note that the proposed care coordination functions include "working with parties in the circle of care". This expectation does not go far enough in ensuring that patients are receiving comprehensive wrap-around care that maintains continuity with their MRP and their primary care teams. We ask that an additional expectation be put in place to ensure that care plans are shared, and seamless communication enabled, with the patient's MRP. Of note, if care coordination were embedded in primary care, this added step would not be needed, as the care coordinators would be directly linked with the patient's MRP and their primary care team.

- Finally, seamless digital communication between home care providers and primary care that can relay accurate information in a timely way is essential to high-quality care. Integrating data systems that enable care coordination, performance metrics, reporting, and research will significantly help to remove "red tape" or barriers that hinder communication, enabling MRPs to receive more timely information about their patient's health. With care still often delivered in silos, patients must often repeat stories, 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.

<u>Clarification needed</u>

- **Eligibility of Providers**

While we are supportive of organizations receiving direct funding be not-for-profits, we are concerned with a potential conflict of interest. It is noted that "Ontario Health would fund home care services through an integrated model of care delivered by a Health Service Provider or Ontario Health Team. Reflecting current practice, these organizations would then generally contract for the delivery of those services." However, Bill 175 says that HSPs can also deliver home care services directly.

This could create situations that may put HSPs in conflict with their funder/contractor role, where those delivering services are also overseeing the delivery of those services. We saw this conflict of interest occur with the LHINs (as HSPs) when they were integrated with the CCACs and

home care services were transferred to them, the funder of the services. This may remain an issue if LHINs are ultimately integrated into Ontario Health.

We also request clarification on how Ontario Heath Teams would fund home care services when we are still unclear about the legal/administrative form of organization of OHTs. OHTs are not yet an entity so we are unclear as to whom this funding would flow and to whom providers, such as family physicians, would make referrals for their patients.

- **Interim LHINs as HSPs**

We have the same concerns with Interim LHINs being HSPs regarding potential conflict of interest, as expressed above under "Eligibility of Providers." How can a LHIN be a HSP and receive funding from Ontario Health if they are part of OH.

We also require clarification on the duration of "Interim." Rather than proposing measures on an interim basis, we recommend seizing this opportunity to transform home and community care and to embed care coordination in primary care.

- **Location of Services: Public hospitals**

This section states "the ministry is proposing to add 'public hospitals' as an eligible care setting for complex clients where the home and community care services pre-dated the hospitalization and are not expected to be needed post-hospitalization." This seems to be in contradiction with an aspiration of *The People's Health Care Act, 2019*, which is to end hallway health care.

A critical component to ending hallway healthcare is to alleviate the need for ALC – patients who need more care than can be delivered at home, but who cannot be discharged until a long-term care placement opens. Making public hospitals an "eligible care setting" for these patients seems to contradict one of the major tenets to ending hallway healthcare, which is alleviating the need for ALC beds in the first place.

We ask for clarification on this portion and that the clarification include what constitutes the in-scope and out-of-scope locations and the definition of each in-scope hospital.

Final Comment

We look forward to ongoing consultation with the associations and organizations in the healthcare sector who represent healthcare providers. To effectively integrate care, and to build strong connections between primary care and home care, health care providers and teams must be engaged in co-designing solutions – both at the OHT and provincial levels.

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