Feedback Form: Proposed Home and Community Care Regulations

As part of the regulation development process, the ministry is seeking feedback on proposed new home and community care regulations.

As you review the proposed regulations, you may wish to consider the following questions:

- Would the proposed regulations create any unintended disruption or risk to current care delivery?
- Would the proposed regulations create any barriers to improving care delivery?
- Would the proposed regulations impose new costs, or enable new cost savings?
- Should there be different or additional requirements in the regulations?
- What lessons from COVID-19 should be applied in the new regulations?

We appreciate your feedback!

Please submit this completed form to HCCB.Modernization@Ontario.ca by July 15, 2021

Your Organization's Name: Association of Family Health Teams of Ontario

Representative First and Last Name: Kavita Mehta (kavita.mehta@afhto.ca)

1. Scope of Services, Service Maximums (slides 9 – 11)

- Do you have feedback on any aspects of the proposed approach set out on slide 10?

The breadth of home and community care services is fulsome. Would the expectation be that one service provider organization (SPO) offers all the home care services for a patient or could several SPOs be contracted? We encourage it be one. The concern with contracting multiple SPOs for a patient is possible confusion or miscommunication around who does what. Also, several of the added community support services fall into the scope of primary care and mental health and addiction care. To ensure continuity of care, will there be an expectation to provide feedback to the patient's most responsible provider (MRP) – their physician or nurse practitioner – so that s/he is in the loop about care being provided in the community? Many of the added community support services, like chronic disease management, should be discussed and consulted with the patient's MRP. Regarding the need to retain security checks, does this include vulnerable sector screening through the police departments? Providers are going into patients' homes, so all patients need to feel secure by knowing that there were safety checks done on the provider before they are invited into the patient's home.

2. Client/Patient Eligibility Criteria (slides 12 - 13)

- Do you have feedback on any aspects of the proposed approach set out on slide 11?

We welcome the changes around service maximums as care should be delivered on what is needed by the patient and not by the number of hours that are defined through an assessment checklist – to be truly patient centric, the metrics for care should be co-designed by the patients, families and caregivers.

No one should have to make a choice about rationing care. With client/patient eligibility, we also welcome the extension of professional services to include all end-of-life care and not only palliation – with many people choosing living at home for their end of life (instead of LTC for example), but quality of life is also so critical as is supporting the caregivers who are providing care in the home. Extending out the eligibility criteria for in-home pharmacy and physiotherapy services to ensure it supports frail and/or homebound individuals ensures that this is supporting individuals who cannot make it into clinics for care – this is a very welcome patient centric approach (especially in urban settings where you may need to take public transit or have to find paid parking for care, both which are not accessible to many). The pandemic has impacted so many individuals and the long-lasting mental health challenges will take decades to address – including psychological services in the home is also very welcome, especially to deal with possible behaviour changes. And with a move towards more virtual care, there also needs to be support to patients/caregivers to attend their virtual appointments – digital equity and access to tools (incl. phones, computers, Internet etc.) is not readily accessible to all nor does everyone fully understand how to attend the appointments. If virtual appointments are a path forward, there needs to be support in the home to enable that. Patient eligibility has always been a sticking point for many as it has been difficult to understand the eligibility criteria – there needs to be transparency around how to access care and it needs to be equitable, no matter where you live. Though there are local nuances of what supports you can have access to, there needs to be minimal threshold of the minimal services you can expect if receiving HCC support. And there is no mention in the regulations around non-insured – what do you do with that population who may not have OHIP but are in need of care? All the regulations need to be grounded in equity to ensure that every Ontarian who needs access to HCC can access HCC services.

- For the proposed new services of Traditional Healing and Indigenous Cultural Supports:
  - Do you have feedback on whether client/patient eligibility criteria should be defined provincially in regulations, or left to be determined more locally (and if they should be defined provincially, what they should be)?

Patient eligibility should be defined provincially in regulations to ensure there is consistency, otherwise you will have different experiences depending on leadership and where you live. But implementation should be co-designed at the local level as defined by what matters the most and those who deliver the care. The regulations should be defined by Indigenous communities as they know their communities the best and should be actively engaged and involved in the development of the regulations.

  - Do you have any other feedback on these proposed new services?

Again, we defer to our colleagues in the Indigenous Primary Health Care Council and others to define the new services – they know their community best and should be actively involved in the feedback and co-design of the new services.

3. Care Coordination (slides 17 – 20)

- Do you have feedback on the proposed requirements for care coordination functions on slide 17?

The future state of integrating care coordination with primary care is absolutely the right approach but should not be done as is – the care coordination functions need to change to prevent hospitalization, if possible, rather than at hospital discharge. Primary care needs to lead care coordination and must be provided the resources to ensure that patients receive wholistic and fulsome care, from cradle to grave. Home care is primary care in the home and as such, the care coordination functions and providers need to be embedded and integrated in the patient's medical home. A foundational element of care co-ordination is a holistic care perspective that includes addressing clinical/medical as well as the broader determinants of health – it also requires a move away from post hospital discharge planning and into more proactive system navigation, keeping the person out of the acute sector as long as possible. The health and social systems of care are extremely complex, and a huge function of coordination should be supporting patients and families in navigating the systems. And that is always done through an equity lens, with a focus on cultural safety and norms – it will be essential that the care coordination function is embedded in equity, diversity, inclusivity and anti-racism. Care plans should also reflect this and be totally co-designed with the patient, caregivers and families but also with their MRP (physician or Nurse Practitioner). It is important that care coordinators not be the 'gatekeepers' of care (through assessment checklists) but care is defined through this consultative and co-designed approach. And the care coordinators can accumulate all information and then be responsible to integrate everything within an integrated electronic health record that all providers involved in the patient/client's care have access to.

- Do you have feedback on the factors to be considered when planning care on slide 18?

There really is going to be a need for consistent hours – there may be a pay per visit approach but for many that work in the community you may need to be on call all day (especially with palliation) but then not be paid for the on call. That is not fair to the provider and needs to be addressed to ensure that support is being provided to the health care professionals working in HCC. Which also relates to wage parity and equity – just generally there needs to be an overall health human resources plan to support all providers, but especially those in community and primary care. There is intense worry that with many people seeking care in their homes going forward, there will not be providers available to care for them. What is the plan and how, through regulations, are you going to make working in HCC a viable and attractive opportunity to health care professionals? Although maybe not in scope of the regulations there are a lot of unanswered questions outside of the care coordination functions – what about care for the medically complex children? How is that training going to be handled – it is very resource intensive but is critical that care be provided throughout the province and not just in communities that are adjacent to children's hospitals. Other nursing programs like rapid response nurses or NPs that work in palliative care and LTC – where do these supports go? Are they going to be embedded in OHTs as well?

- Are there any rules or parameters in addition to what is set out on slide 19 that the ministry should consider regarding an HSP or OHT’s assignment of care coordination functions?

There really needs to be a one-record for the patient’s medical and social histories – we assert that the patient’s primary care EMR chart is the ‘source of truth’ and if CHRIS is the system that will be used in HCC, it MUST be integrated within the primary care EMR (at least the top 3 systems) to ensure that the MRP is aware of what is happening in the care delivery of their patients. Standalone portals do not work for busy clinicians and while HRM is an option, it is not easily searchable. Through regulations there should be enforcement of the EMR providers to prioritize integration of CHRIS within the top 3 primary care EMR systems so that it is the one record…and there does not, then, have to be duplicative reporting by the providers nor duplicative storytelling by the patients. With the integration and/or embedding of supports directly into the community there needs to be earmarked funds to support capital funding if the staff are relocated – the best team-based care is provided when there is colocation and not through referral-based medicine. This allows all members of the patient’s care team to access one another to co-design the care plan with the patient and family – the one time – and not through the patient having to have multiple visits and work with multiple providers. But capital funding is not easy to come by and needs to be supported. And if these resources are embedded then there must be consistency in managing the contracts – not every community or primary care entity has capacity to manage large SPO contracts so that needs to be kept in mind. The care coordinators are well suited to be managed in primary care but service delivery outside of direct home care through the coordinators may be better managed through larger organizations who have the capacity to manage more complex contracts.

4. Bill of Rights, Locations of Service, Eligible Providers, Methods of Delivery (slides 21 -25)

- Do you have any feedback on the proposed items on slides 21-25?

Bill of Rights that is more inclusive and comprehensive is welcomed but should also be clear and concise, not weighed down in language that is difficult to understand. On the flip side, there also needs to be support for the providers going into the homes and the expectations for provider safety as well – our health care providers have had an exceptionally difficult last few years and they need to be supported and feel that they are also free from bullying behaviour. There needs to be dual expectations and accountabilities – and often it is not the provider that holds the contract of what services are being provided so the actual SPO that employs the provider(s) need to be held to account as well. For location of services, please provide clarity around the comment ‘the ministry is no longer proposing to allow home and community care services to be provided in hospital’ – does this mean that HCC will only be in the homes and no longer in the hospitals? Eligible providers – 30 to 40% of SPOs are for profit so how do they fit into the service delivery of supports, given that NFP organizations do not have the capacity to manage the 100% of HCC services needed? What is the role of for profit and what checks and balances will be in place with them – this needs more clarity. The move towards virtual care has been instrumental in supporting care during the pandemic but should not be the natural default for care in the home – please ensure there is actual guidance on what is appropriate for virtual care but default to in person care as part of usual care. And if care is being delivered by electronic means, ensure that the MRP is also aware of what the visit was about and integrate the notes from the visit into the patient's primary care EMR.

5. Charges for Services (slide 26)

- Do you have any feedback on the proposed items on slide 26?

What does co-pay really mean and would it be defined by the services being offered or the patient's financial status? The idea of co-pay must be done through an equity lens to ensure that care is being delivered equitably, regardless of financial stability. There is so much variation at the regional levels and you should not have to pay for services depending on where you live – this is where it will be important to ensure there is a minimal standard of expectations in each geographic region. And there needs to be a robust grant funding pool to help support patients and caregivers get access to funding if they cannot co-pay for services but it cannot be through a cumbersome application process.

6. Plans to Prevent Abuse, Complaints, Appeals, Patient Ombudsman (slides 27-30)

- Do you have any feedback on the proposed items on slides 27-30?

Training in recognizing abuse is so critical so that is welcome – please also ensure that providers are also aware of their rights if they feel unsafe in the homes as well. They should not be subject to harassment or abuse just because they are delivering care (incl. with caregivers). Complaints need to be well thought through in the implementation – every organization has its own complaints process and the process that is outlined in this slide may not align with other sector responses. If the HCC staff is embedding in primary care, for example, it will be important that the primary care complaint process and the HCC complaint process are aligned. It would be very helpful to have templates and policies developed that each region can adopt and adapt otherwise there may be a lot of legal advice (and funding to support) sought out around developing the process. At minimum, the Ministry should provide a framework around expectations. Only acute care, home care and LTC are under the Patient Ombudsman's purview – for OHTs to truly succeed there needs to be consistency around process related to complaints. For primary care that is team based it gets tricky because physician complaints are managed through CPSO and all other professionals (nurses, dietitians, pharmacists etc.) through their regulatory colleges as well. If the HCC staff is employed in a different sector, then there needs to be alignment around extending the Patient Ombudsman's purview to encompass the full employer and/or OHT – the patient and family should not have to navigate such a complicated complaints process.

7. Self-Directed Care, Residential Congregate Care, Other Related Amendments (slides 31 - 35)

- Do you have any feedback on the proposed items on slides 31-35?

Under self-directed care we recognize that program parameters will be set out more in policy rather than legislation or regulations but would also comment that there needs to be recognition of social determinants of health in that care – financial security, housing, food insecurity…these are not traditional 'health care' services but it should be part of the basket of services in care delivery.

8. Other feedback

- Do you have any other feedback on the proposed regulations?

There is a lot of emphasis on Ontario Health Teams in the regulations – given OHTs are not an entity (i.e., not incorporated), who actually would hold the contracts and/or assume accountability? With many host organizations being large institutions there is a lot of concerns that they will assume these professions/staff if the OHTs devolve. How will the Ministry make sure that does not happen as these HCC supports are needed very much for the community? Additional feedback includes what is the definition of homebound patients – guidance on definition would be helpful (limited transportation? Immobile? No family or socially isolated?). There is a lot we have learned and continue to learn through the pandemic and fundamentally it comes down to those that are the most vulnerable need to be prioritized in the build back of the health care system. With the experience many had in LTC or RHs, many are going to choose to seek care in their homes as long as possible – in countries that do that well, they have prioritized investments in community and primary care so that their citizens can have the best quality of life they can have. Our hope is that Ontario does that as well and these regulations will create more robustness and more integrated home and community care with the rest of the health care system.