November 11, 2023

Home and Community Care Branch
Strategic Partnerships Division
Ministry of Health
9th Floor, 56 Wellesley St W
Toronto, ON M5S 2S3

Re: Convenient Care at Home Act, 2023

The Ontario Medical Association (OMA) appreciates the opportunity to participate in the Ministry's consultations regarding the proposed *Convenient Care at Home Act, 2023*, which would consolidate the 14 Local Health Integration Networks into a new service organization named Ontario Health atHome.

This submission will include our general policy advice on strengthening home and community care and specific feedback on the new legislation.

Ontario's physicians know first-hand the home care experiences of their patients, as the point of contact for referral, as providers of medical care in the home, and as physicians overseeing the delivery of medical care. The OMA continues to advocate for a high-quality, timely and equitable home care system.

In October 2023, the OMA released a new report, *Prescription for Ontario: Doctor's Solutions for Immediate Action*. One of the highest priorities is to increase community capacity and tackling hospital overcrowding. Too many acute-care hospital beds are occupied by patients whose acute medical issues are stable and can be discharged but lack the appropriate support in the community, including home care and palliative care. This bottleneck of patients, referred to as alternate level of care, has existed in Ontario for many years, with its root causes remaining unresolved.

No one solution will fix hospital overcrowding. We have convened physicians and stakeholders to identify the top solutions that will yield the greatest results. They include:

1. **Appropriately fund home care and home care providers**. The Ontario government must accelerate its efforts to recruit and retain home-care staff, which means paying them a wage that makes it abundantly clear just how vital they are.
2. **Embed care coordinators and home care within primary care and Ontario Health Teams (OHTs)**. Home care needs to be integrated within a team-based care model, which could be done by embedding both care coordinators and home-care professionals in primary care and OHTs.
3. **Ensure all Ontarians have access to palliative care when they need it**. The province should expand access to on-call/after-hours palliative specialists. Primary care providers in all care settings should have increased access to regionally organized specialist palliative care resources, such as dedicated palliative consultation teams.
4. **Expand programs that provide hospital-level care in the patients' homes.** These programs involve flexible home visits, remote monitoring and 24/7 access to health-care professionals. So far this has only been implemented on a small scale in Ontario.

Specific feedback regarding the Convenient Care at Home Act, 2023

The OMA appreciates the government's efforts to build a better and more reliable home care system. The proposed initial provincial centralization of the 14 LHINs followed by subsequent decentralization of home care delivery to 57 OHTs will require massive change management resources to maintain system stability and close focus on ensuring continuity of care and equitable access to care. It should be noted at the outset that it is difficult to comment on some aspects of the proposal without specific details around change management of the proposed changes. Critical consideration must be given to the implementation of the proposed changes for the overall success of home care delivery across Ontario.

Centralization of LHINs

The goal with the initial centralization should be that Ontario Health atHome set standards for home care, ensuring that it is of high quality, provided at appropriate levels commensurate with need and available when and where people need it. Currently, accessing home care can be a postal code lottery. A patient's postal code can determine which kind of home care they are able to access, both in terms of quality, timeliness and intensity. Defining quality standards would help drive improved equity, access and quality in home care.

Ontario HealthatHome also holds a key role in system level planning, building, and improving centralized IT infrastructure, creating common forms, and facilitating that home care becomes effectively embedded in acute and primary care through OHTs. Ontario HealthatHome must however also specifically spell out a strategy to avoid "one-size-fits-all" approaches, prioritizing autonomy for OHTs and healthcare professionals. Centralization should not mean rigidity.

If centralization efforts are implemented appropriately, OHTs could benefit from the efficiencies of a central shared services model to support their future provision of home care. Ontario HealthatHome must provide OHTs with the resources and tools they need to focus on clinical care provision, patient outcomes, quality improvement and integration with all providers across a patient's care journey.

If implemented poorly, there is a risk of creating a centralized entity that fails to understand and address the vastly different socio-economic demographic issues across Ontario. This risk is particularly high for northern and rural Ontario, where home care in many places is limited or fully absent due to extreme staffing shortages. In too many instances, patients who wish to be cared for at home, including at the end of their life, are admitted to hospital, simply because no home care support is available. We strongly recommend that a robust evaluation process be put in place to review what is working and what needs to be improved during modernization efforts.

Forms

Work is underway between the Ministry of Health and the OMA to address the administrative burden faced by doctors, one of the key contributors to physician burnout. In consultation with physicians on home care, physicians have voiced the need for a single, standardized referral form for home and community services. Currently, physicians must look up the patient's postal code, find the correct LHIN, print the correct form, and fax it back to the correct LHIN. Time could be saved if there was only form to use. Ideally, if this referral form could be uploaded through the physician's EMR system and/or e-referral platforms that would reduce time spent on paperwork.

Responsiveness of home care

We need a much more responsive healthcare system that is there when patients need it. Currently there are few, if any, enablers in place that allow home care to respond at off-hours to help keep people out of the emergency department. Ontario HealthatHome should help to facilitate OHTs to be able to provide home care 24/7 to reduce avoidable emergency department admission. Referral to home care should also be available 24/7. At present, intake closes at 8 PM on weekdays and is not available on weekends. This is directly contributing to the alternative level of care crisis, as patients must either go to the emergency room, be admitted, or stay admitted in hospital, until intake reopens during business hours.

Equitable access to care

As mentioned above, Ontario Health also needs to play a key role in supporting OHTs to "even out the playing field" for patients. There needs to be consistent provision of home services, e.g., nursing, personal support services and therapies, regardless of where in Ontario a patient lives. Unfortunately, access to home care and palliative care is often reserved for the privileged few who have the resources to support a death at home.

OHT readiness

OHTs are at very different levels of maturity, and many need to develop necessary operational infrastructure to organize and deliver home and community care services. For example, in northern and rural Ontario, OHTs are less developed, and the new centralized home care structure must take this into account before home care is transitioned.

There should be a process in place to assess OHT readiness in advance of the transfer of responsibility for home care. This readiness assessments must include feedback from patients and their families as well as health care professionals, including physicians. Their questions and advice must be addressed and considered.

The OHTs who handle the transfer of home and community care successfully should be showcased, so other OHTs can emulate their organizational set-up and strategies implemented. For example, in Ontario Health East-Champlain, the Kids Come First Team together with CHEO have assumed responsibility for child and youth home care services. This has been successful and has been organized with consultation of physicians and other clinicians.

Care coordinators

Home care coordinators must be embedded within primary care, acute care and the OHT to support better collaboration between care coordinators and physicians. Physicians often have little to no say in what home care resources are allocated to a patient, even though they recognize the clinical needs of the patients. Due to budgetary considerations, care coordinators often make service allocation decisions based on rigid funding envelopes, rather than actual clinical needs. For example, a patient with a cancer diagnosis and no palliative care needs is much more disadvantaged for resources, compared to a palliative patient.

As home care coordinators transfer into Ontario HealthatHome and eventually become integrated with OHTs, it will be important that physician access to care coordinators is not disrupted. Ontario HealthatHome should pay specific attention to ensuring that physicians outside of OHTs can access care coordinators and services for their patients in the same way physicians within OHTs can.

Communication between care-coordinator, home care staff and physician

Communication between the physician, the care coordinator and the nurse in the home needs to be improved. Because there is no digital infrastructure enabling this communication, nurses' notes are often written on paper left in the patient's home. The Client Health & Related Information System (CHRIS) used by care coordinators is often inaccessible to anyone else. Proper infrastructure to share information is needed, e.g., a cohesive care plan must be accessible to all members of the care team, for the community, emergency department, and inpatient care. The Ministry could consider opportunities for collaboration with OMD to drive digital integration.

Contracts

The OHT model is a promising opportunity to re-think the visit-based contractual service model of home care. We need to shift home care to a team-based practice model that supports continuity of care. As OHTs start to assume more responsibility for home care, they should have the flexibility to choose how and which home care service provider organization they contract with - and whether they will continue with the contract model. In some cases, this may mean streamlining the number of service provider organizations and focus on those that can deliver the full suite of in-home services and live up to performance standards. The model of evergreen contracts must be reviewed carefully and negotiations for these contracts should not strictly favour large companies. Barriers to new entrants must be minimized. In other instances, it should also be possible to embed professionals responsible for delivering home care in acute or primary care, e.g., employment of home care staff within the OHT.

The Ontario Medical Association is pleased to participate in the ministry's consultation regarding the proposed *Convenient Care at Home Act, 2023*.

We look forward to opportunities for continued collaboration between the OMA and the Ministry, Ontario Health and Ontario Health atHome, once established, to improve home care and community care.

Sincerely,

Adam Farber
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Economics, Policy & Research