A Review of Bill 175, *Connecting People to Home and Community Care Act,* 2020

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Submitted to: The Standing Committee on the Legislative Assembly
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Background:

On February 25th, the Ontario government introduced Bill 175, *Connecting People to Home and Community Care Act, 2020.*

Some of the positive proposed changes to come from this Bill include:

- Enabling home care providers to provide care coordination which will embed the service closer to the point of care;
- Removal of maximum service levels signaling the accommodation of a different focus service provision; and
- Funding based on outcomes and goals as opposed to hours of care.

We applaud and appreciate the great work done by the government in creating Bill 175, *Connecting People to Home and Community Care Act, 2020*. However, we have some recommendations for change that will help to achieve the goals of Bill 175 and result in better access to home care for Ontarians. Specifically, Bill 175 relies heavily on new regulations, rather than being prescriptive in the legislation itself. We believe there are areas related to the oversight of the system which the government intends to address in regulations, which we feel would be more appropriately dealt with in legislation.

Concerns and Recommendations:

Eligible Providers

Proposed amendments to the *Connecting Care Act, 2019* would require organizations receiving direct funding from Ontario Health to provide home and community care services to be not-for-profit. Proposed amendments would also require organizations be Health Service Providers (HSPs) receiving direct funding from Ontario Health to provide home and community care services to be not-for-profit. The definition of HSP under the *Connecting Care Act, 2019* would be repealed to remove "a person or entity approved under the *Home and Community Care Act, 1994* to provide community services", and replacing it with "a not-for-profit entity that provides home and community care services."

Bayshore's largest concern is the language restrictions limiting the delivery of home and community care services to not-for-profit corporations. Business organizations bring the ability to invest in innovative new programs introducing digital health solutions and strong quality management systems to support delivery of services. Bayshore is an example of one of these business organizations. **We are concerned about our eligibility to continue to be an approved home care agency and our ability to continue to invest in the home care space.** As a Service Provider Organization (SPO) we believe this would create an uneven playing field by recommending an organization with one corporate status over another rather than selection be based on quality of service or capacity to provide services.

There are serious implications of this model including home care dollars being syphoned by HSPs where services are contracted out and the HSP drives no incremental value for patients and families.

Recommendations:

We recommend a new section be added to the *Connecting Care Act* through an amendment to that Act made under Bill 175 which would read as follows:

"A home care services provider shall be either a business organization or a not-for-profit organization or entity. A community care services provider shall be a not-for-profit entity."

We also recommend that Bill 175 specify that HSPs and OHTs (and LHINS, in the transitional period) are able to contract with home care service providers to provide home care services (as defined). As the Bill is currently worded, it is not clear that the right to contract with providers is intended, and this must be clarified.

Scope of Services

The umbrella definition of "home and community care services" will be foundational to the operation of the home care sector, as well as the *Connecting Care Act*, and therefore should be included in the *Connecting Care Act* directly, not handled through regulations.

Recommendation: We strongly recommend the term "home and community care services" be defined in the *Connecting Care Act* through an amendment to Bill 175 at Committee, rather than through Regulation.

The Ministry is considering adjusting how groups of services are referred to in regulation to avoid confusion and better align with sector nomenclature. For example, the current distinction between "community services" and "community support services" causes confusion. The Ministry is proposing to use the umbrella term of "home and community care services" and distinguish between two categories of services: "home care services" and "community care services".

While Bayshore believes it's important to delineate the services of home care and community supports, we believe the ministry's proposal is also confusing. If the intention is to reduce confusion, then they must remove the overlap in services listed under "home care services" and "community care services".

In the proposed regulations, "homemaking services" is listed under both home care services and community care services, despite not being a service provided by home care providers currently. This should be removed.

Further, "personal support services" are listed under both home care services and community care services. Again, this should be removed from "community care services" and only listed under "home care services", as it is home care providers that currently provide such care. The home care sector has significant clinical expertise and provides oversight for personal support services, whereas there is no clinical capacity in community support services.

Recommendation: Personal support services needs to remain under 'home care services' due to the clinical expertise, best practice guidelines, and inter-professional practice within the home care sector. Community care services would best be scoped to homemaking and lower acuity recipients where social determinants are factors that affect ability to achieve health outcomes. The definitions of 'home care services' and 'community care services' should be outlined in the *Community Care Act* itself and not left to Regulation.

Under scope of services, the Ministry is also proposing to include residential accommodation services as a home and community care service, which would enable funding for lodging, meals, unscheduled care needs, housekeeping, linen/laundry, residential safety and security check, and social and recreation services within a residential congregate care setting. This would enable our transitional bundled care models to include accommodation fees which would enable integrated care plans resulting in faster discharge from hospital for ALC patients.

Recommendation: We are in agreement with including residential accommodation services as a home care service.

Location of Services

The Ministry is proposing to maintain the existing settings outlined in the *Home Care and Community Services Act, 1994* and Ontario Regulation 386/99. This includes a person's home, other community settings, congregate care settings, schools, and long-term care homes in the circumstances outlined in that regulation.

With the knowledge learned from the COVID-19 pandemic, we recommend removing any restrictions or prohibitions from home care providers to offer nursing, personal support, and therapy services in congregate settings. This may help build capacity within the entire home care sector. Home care has significant clinical expertise and capacity to support with Infection Protection and Control Canada (IPAC) practices and the development of care plans for patients regardless of setting.

The Ministry is also proposing to add "residential congregate care settings" as a location in which home and community care services can be delivered. Regulations would provide a legal framework for the funding and oversight of non-licensed residential congregate care models. We agree with establishing a residential congregate care setting as it should improve the ability to deliver care in non-licensed residential settings where patients do not require the intensity of resources provided in a hospital or long-term care home, but care needs are still high enough that they need to be cared for outside of the home. For example, three seniors with similar care needs could receive care in a three-bedroom residence and support the delivery of a cluster care model. This would help to relieve the pressure on the long-term care waitlist as frail elderly seniors can be diverted from long-term care placement through such settings.

Recommendation: Remove any restrictions or prohibitions from home care providers to offer nursing, personal support, and therapy services in any residential congregate setting where a

senior defines the setting as 'home'. We encourage the development of more un-licensed residential care settings (i.e., shared accommodation in personal residences). Add regulations that allow for home care service providers to transfer copayments to residential congregate care settings.

Method of Delivery

The Ministry is proposing to continue to allow 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. Home care services need to recognize integrated funding models and bundles of care where virtual delivery of services and remote patient monitoring are inclusive in a bundle of care.

Recommendation: We strongly agree that technology and digital solutions need to be incorporated into methods of delivery. However, the Regulation should clearly stipulate how virtual care should be delivered, including that home care service providers, not the HSPs/OHTs/LHINs, must determine which clients should receive virtual care, and for what services. Home care service providers could then be held more accountable for outcomes given more flexibility in selection of technology solutions at program level.

The Regulation should state that home care service providers can bill for more than one virtual visit in a day for a visit that is longer than the 30 minutes.

The Regulation should highlight that visit time includes both direct and indirect time. Indirect includes documentation and time related to all communications with 3rd party vendors for equipment, consultation to caregivers.

The Regulation should eliminate caps to service guidelines – with shorter visits there may be a greater number of visits (e.g. 8 short virtual visits to 5 long visits). Regulation should also include the ability to remove or adjust the 2% volume variation restricting transfer of volumes between home care service providers based upon local capacity factors.

The Regulation should expressly state that virtual visits do not count towards market share numbers as there will be an artificial inflation to the numbers related to the increased number of shorter visits. This may skew bill rate bands in the existing contracts.

Eligibility for Services

The Ministry is also seeking feedback on whether to introduce flexibility for the eligibility criteria for pharmacy and physiotherapy services. Currently, a patient must be unable to access services in a setting outside their home because of their condition. We believe this can be a barrier to effective care, such as if a client is ambulatory.

We agree with eligibility being expanded for specialty pharmacy. Specialty pharmacy differs from retail pharmacy in that our specialty pharmacy services include pharmacist consultations, pump training, infusion education and administration consultation, and can be bundled as part of an integrated solution with nursing services. Introducing flexibility criteria for specialty pharmacy will allow for more infusion medications to be administered in the home which helps to save health care dollars and reduce the likelihood of hospital re-admissions while simultaneously improving the quality of life for patients and their families.

Further, there is no cost for parking at community based infusion locations compared to hospitals, resulting in improved patient satisfaction. Patients who receive infusion medications in community also avoid the risk of contracting hospital borne infections; a study found that 37% of patients were harmed by infection during their hospital stay. We also support broadening access to physiotherapy services inside the home as physiotherapy has demonstrated a positive impact on health outcomes.

> **Recommendation:** We are aligned with expanding eligibility criteria for physiotherapy services and pharmacy services, specifically specialty pharmacy. Eligibility criteria for the delivery of pharmacy and physiotherapy services in the home should be included in the Regulation. We also recommend expanding therapy services to include occupational therapy and speech language therapy as well as physiotherapy.

<u>Existing Contracts</u>

While the regulatory and legislative changes do not go into detail in terms of existing relationships, communications released by government identify how existing contracts will work going forward. During the transition, patients and caregivers will continue to access home and community care services through the same contracts.

Existing contracts bind a LHIN from floating more than 2% volume between providers due to capacity challenges without having first gone through a QIN process. The Home Care Sector needs to allow for more flexibility regarding capacity and support greater swings in volumes based upon quality and capacity to deliver services. This allows for a phased approach to transitioning volumes to providers that can demonstrate improved quality and capacity.

> **Recommendation:** The language in the legislation and regulations need to be strengthened by including the ability to contract with business organizations regardless of corporate status, as well as additional language addressing how existing contractual relationships will continue or be amended over time.
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> We believe legislation and regulations need to address home care services providers and their role, and should also note that corporate status should be irrelevant in the selection of home care providers. We also recommend modifying the 2% volume float to be increased to allow transitioning of volume from one provider to another in order to match capacity to service volume needs within the sector.

Care Coordination Functions

The Ministry is proposing to require home and community care Health Service Providers (as defined under the *Connecting Care Act, 2019*, which would include LHINs) 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 partner organizations with the goal of reducing transitions for clients, eliminating duplication in assessment and care planning and improving system navigation.

We agree with changes to care coordination function to reduce duplication in assessment and care planning. We also believe it should only be embedded where necessary and limited to those patients with complex care needs. Care coordination should only be included to the extent that it adds value to the client experience and only if it enhances the care experience or outcomes of that care. Care coordination should be eliminated from clinical pathways where there is predictable and episodic care that can be managed by provider professional services.

Most specifically, we believe the definition of HSPs being responsible for care coordination needs to be changed to HCPs being responsible for care coordination. Care coordination should be able to be distributed across a team, and in cases of bundled funding programs between HSPs and SPOs, the current definition limits the ability of SPOs to take over care coordination when needed, limiting the ability to provide integrated and coordinated care to patients.

> **Recommendation:** Change definition from only Health Service Providers being responsible for care coordination functions to include and allow home care service providers to be responsible for care coordination functions as well.

Service Maximums

We are in full alignment with the removal of service maximums. All home care recipients should have a care plan that meets their care needs in order to support discharge from acute-care settings and prevent inappropriate placement in long-term care. We also recommend modifying the 2% volume float to be increased to allow transitioning of volume from one provider to another in order to match capacity to service volume needs within the sector.

Complaints

We are in agreement with the proposed additions to the list of complaint topics as well as establishing a process for reviewing complaints made by patients and families.

> **Recommendation:** We recommend a robust complaints escalation process as an input to provider quality management systems that ensures accountability and allows patients and families to feel confident in the care that is delivered.

Self-Directed Care

We are in alignment with the proposed changes that introduce self-directed care as an option for patients to purchase and manage their own care.

> **Recommendation:** We recommend the introduction of self-directed care as an option so that patients and families can select a pre-qualified home care service provider of their choice.

LHINs as Health Service Providers

Proposed amendments to the *Connecting Care Act, 2019* would enable LHINs to be deemed Health Service Providers under the Act on an interim basis. Regulations would ensure that certain provisions of the *Connecting Care Act, 2019* and proposed regulations under that Act pertaining to the delivery of home and community care services would apply to all Ontario Health-funded home and community care providers would apply to LHINs as well.

In general, we are not in agreement with LHINs being deemed HSPs for the provision of direct services (i.e., case management). However, we do agree with LHINs being deemed HSPs in the conveyance of assets and amalgamation of assets under *Connecting Care Act, 2019.*

> **Recommendation:** Consider revising language in regulations to deem LHINs as HSPs in the conveyance and amalgamation of assets, but removing the ability for LHINs to be responsible for the provision of direct services.

Health Information Custodian Status

We are in full agreement that home care providers being deemed health information custodians (HIC). This would support more fulsome health information exchange across providers within the system.

> **Recommendation:** Within the provincial contract template for home care all language regarding agent status must be removed.

About Bayshore:

Bayshore HealthCare is one of the country's leading providers of home and community health care services and is a Canadian-owned company. Bayshore HealthCare has been a recipient of Canada's Best Managed Companies award since 2006.

With over 100 locations across the country, including home care offices, pharmacies and infusion clinics, Bayshore has more than 13,500 staff members and provides care to over 350,000 clients. We are dedicated to enhancing the quality of life, dignity and independence of all Canadians, by providing customized care plans and solutions that allow clients to remain in the comfort of their own home.

In 2019 alone, Bayshore has provided over 4 million hours of personal support, 1.5 million hours of nursing care and 67,000 hours of therapy to patients across Ontario.