Ontario College of Family Physicians

Leaders for a healthy Ontario

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

Submission to the Standing Committee on the Legislative Assembly

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Introduction

The Ontario College of Family Physicians (OCFP) represents 13,500 family physician members across Ontario providing primary and secondary care across all settings, including home and community care. We are pleased to provide feedback to the Standing Committee on the Legislative Assembly regarding Bill 175, *An Act to amend and repeal various Acts respecting home care and community services*.

As the province moves towards a system that is seamlessly connected for, and *around*, patients, a strong primary care sector with solid connections to home and community care is the starting point. To successfully integrate home care in Ontario Health Teams (OHTs), the Patient's Medical Home (PMH) and the Patient's Medical Neighbourhood (PMN) provide the framework to do this. The PMH/PMN vision is a system in which patients can easily access care throughout every stage of their life, which 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]

Safe, effective, and efficient home care maintains continuity with the patient's most responsible provider – often the family physician, who knows that person best because of a trusted relationship developed over a lifetime. This continuity of care is a key component of PMH/PMN principles and a pertinent variable in patients' recovery and overall health. The evidence is clear: patients who were more closely followed by the same family physician were shown to have lower readmission rates and lower mortality. Maintaining continuity with the primary care provider has also been shown to improve patient satisfaction and reduce system costs.[iii]

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 doctors communicating with home care and community services. Less than a third of family doctors in Ontario say they, or other personnel in their practice, routinely communicate with their patient's case manager or home care provider. Slightly more than a third of Ontario family doctors say it is easy, or very easy, to coordinate their patients' care with social services or other community providers.

Hence, central to successfully advancing home and community care, is removing current "red tape" and barriers that hinder connections between primary care and home care – most notably, by building solid connections through care coordination and direct connection between the patient's most responsible provider (most often the family physician) and the provider in their home to determine that patient's care needs. Home care is essentially primary care in the home, and meaningful improvements must reflect and enable that reality.

While advancements in Ontario's home and community sector have long been overdue, they are now more urgent than ever on the heels of the COVID-19 pandemic. Though the effects of the virus were crippling throughout the province, many patients did not get the care needed to remain safe and well in their home. To protect hospitals from crisis-level surge capacity, patients were told to stay home, or were transferred to long-term care. We know the devastating effect of this, placing an already vulnerable population at significant risk for deterioration and most unfortunately for too many, it led to the unnecessary deaths of residents and staff. Andre Picard of the Globe and Mail noted this in an article published on June 16: "A survey of three large Canadian home-care providers – SE Health, Bayshore and VON Canada – found that in the weeks after lockdown, home-nursing care dropped 22 per cent; personal support workers' services were reduced by 31 per cent; and home-based therapies such as physiotherapy and occupational therapy plummeted by 65 per cent for those big three providers."

Many of the devastating consequences of the pandemic could have been mitigated if home care and primary care were better supported and equipped to have patients cared for in their homes. We respectfully and sincerely ask the Standing Committee to seriously reflect on, and apply, the hard lessons learned from this pandemic to prevent further unintended consequences and a more dire crisis down the road.

Within this context, the OCFP offers the following recommendations ***to enable, support, and maintain continuity of care between the patient at home and their family physician, anchored in a strongly connected and integrated system:***

1) Remove barriers and "red tape" that hinder family physicians (FPs) from obtaining information in a timely manner about their patient receiving home care.

2) Enable shared care between primary care and home care by anchoring care coordination in primary care.

3) Expand equitable access to comprehensive team-based care in primary care, that is also connected to home and community care, to address patients' complex, social and mental health needs.

4) Enhance FP access to home care services for their vulnerable patients, such as the frail elderly, so that they can continue to stay in their homes for as long as possible.

5) Maintain FP and patient/caregiver ability to leverage modern technologies such as virtual care.

6) Exclude FPs from the Health Service Provider definition.

Recommendations

1) Remove barriers and "red tape" that hinder family physicians (FPs) from obtaining information in a timely manner about their patient receiving home care.

- Our members often describe considerable challenges in accessing information about their home care patients' progress and treatment plans, and frustrations about not receiving important patient updates in a timely manner or at all.
- Integration of home and community care in the OHTs must enable the patient's family physician and home care provider to be directly linked – and in a way that enables efficient and timely two-way communication – to best manage care.
- Seamless digital communication between home care providers and family physicians is essential. Integrating data systems and enabling that direct connection will significantly help to remove "red tape" or barriers that hinder communication, enabling FPs to receive more timely information about their patient's health.

2) Enable shared care between primary care and home care by anchoring care coordination in primary care.

- Care coordination within OHTs ideally 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).
- Care coordination in primary care that is strongly connected with home and community care will maintain continuity of care and enable comprehensive wrap-around care to patients' complex needs.
- The OCFP supports leveraging the vital role of the 4000+ care coordinators (funded through the LHINs) into supporting care coordination and system navigation. As referenced earlier, the patient's family physician and home care provider should be directly linked – and in a way that enables efficient and timely two-way communication – to best manage their care.
- However, deploying care coordinators alone will not suffice in truly integrating home and community care. To meet home care patients' complex medical and social needs, care coordinators should be strongly connected to comprehensive team-based care that is based in primary care. This is described further in the next recommendation.

3) Expand equitable access to comprehensive team-based care in primary care, that is also connected to home and community care, to address patients' complex, social and mental health needs.

- As stated earlier, home care is primary care in the home, in which patients receive person-centred and comprehensive services to address their various health needs and condition. Care coordinators play a vital role in connecting patients with the right care.

However, to truly connect and integrate home care with primary care and the rest of the system, care coordinators should be strongly connected with interprofessional healthcare teams, which are based in primary care, to meet home care patients' complex medical and social needs.

- We support increasing equitable access to team-based care across the province through the expansion of core or "minimum" teams that maintain continuity of care between patients and their FP.
- Teams should leverage the right mix of interdisciplinary healthcare professionals that would simultaneously support at-home provision of clinical care, provide mental health and addictions care, and help coordinate care for patients, including navigating access to resources in the system that help address social determinants of health. In this model, continuity of care is protected and enhanced, communication across the interdisciplinary health team is strengthened, and the capacity of healthcare providers to work to their full scope of practice is activated.

4) Enhance FPs' access to home care services for their vulnerable patients, such as the frail elderly, so that they can continue to stay in their homes for as long as possible.

- Family physicians in Ontario often express significant frustrations and difficulty in accessing home care services for patients in their communities. Some of this challenge is due to FPs not being able to identify services within their community; however, the major barrier is that many of their patients are not deemed eligible for, and are often refused from, receiving existing home care services. 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. The lack of available home care for these patients risks deteriorating their conditions further which, in turn, may lead to preventable hospitalization.
- OHTs should ensure that family physicians can easily access information about the availability, wait times, eligibility and types/range of home care services provided in their community.
- In examining the availability and eligibility of home care services within the community, OHTs should ensure that patients who have been historically denied services be ultimately connected to home and community services, so that no patient is left behind.

5) Maintain FPs and patient/caregiver ability to leverage modern technologies such as virtual care.

- Family Physicians have quickly adapted to leveraging virtual care to continue providing care to their patients. Policy and implementation supports will be required to maintain this level of care in a post COVID-19 world, including support of optimal use by both FPs as well as their patients and caregivers.
- It is important to note that leveraging modern technologies will require a certain level of technological literacy and access. This is key for patients receiving care in their homes as many have unique challenges with video conferencing, emailing, printing, etc.

Directly assisting with this “digital enabling” is an added need to effectively support virtual care in the home.

- The above is especially relevant for those living in rural, remote, or low-income areas which may have low access to basic technology, such as high-speed internet. Left unaddressed, an unintended consequence of technology expansion is greater inequity between those who are digitally fluent/privileged and those who require further assistance/supports. 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.

6) Exclude Family Physicians from the Health Service Provider Definition.

- The definition of a Health Service Provider in Bill 175 is open ended, allowing additional entities to be prescribed by future regulations. Entities defined as a Health Service Provider have significant requirements placed on them including possible directives issued by the Minister of Health or Ontario Health on operational priorities. Similar definitions of Health Service Provider in previous legislation, such as the Local Health System Integration Act, contained specific exemptions from this definition for physicians as well as for health professional corporations. The OCFP supports the exemption of physicians and health professional corporations as a Health Service Provider and believes such an exemption should be carried forward to Bill 175 as well as other affected bills.

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[ii] Delnoij D, Van Merode G, Paulus A, Groenewegen P. Does general practitioner gatekeeping curb health care expenditure? J Health Serv Res Pol. 2000;5 (1): 22 – 6. Crossref, Medline, Google Scholar
[iii] *BMJ* 2017; 356 doi: https://doi.org/10.1136/bmj.j84 (Published 01 February 2017)
[iv] 2015 Commonwealth Fund International Health Policy Survey [Internet]. Washington, DC: The Commonwealth Fund; 2015 [updated 2015 Nov 19; cited 2016 Mar 16].