# SENIORS FOR SOCIAL ACTION (ONTARIO)

## *SYNOPSIS*

# HOME CARE MODERNIZATION ZOOM SESSION

**January 23, 2024**

**With Rhonda McMichael, Assistant Deputy Minister,
Strategic Partnerships Division
and
Amy Olmstead, Director, Home and Community Care Branch,
Ministry of Health**

***Please note that this synopsis was prepared based on the observations of SSAO volunteers and other attendees and has not been approved by Ministry of Health personnel.***

***We very much appreciated Rhonda McMichael and Amy Olmstead joining us for this session and for being open and forthright in their presentation and response to questions. Time limited to some degree their ability to respond fully to some questions and you will see this reflected in the responses to audience questions.***

***SSAO looks forward to being part of the solution in achieving a more responsive and integrated Home Care system in Ontario.***

**Preamble**

For years, Home Care has functioned largely independently of the larger health care system. It has also gone through several iterations – Community Care Access Centres (CCACs), Local Health Integration Networks (LHINs), and Home and Community Care Support Services (HCCSS). It is against this backdrop that Home Care Modernization is occurring.

**Presentation Synopsis**

***Goals of Home Care Modernization***

This session began with an explanation of the goals of Home Care Modernization which are: to better connect care through local Ontario Health Teams (OHTs) in order to keep people in their own homes and out of hospitals and long-term care; to improve the transition process as people move from hospitals and primary care to care at home; to bring patients closer to how home care decisions are made; to work with Ontario Health

Teams (OHTs) as they transition to taking on Home Care delivery. The entire plan is built on the document released in February of 2023 entitled Your Health: A Plan for Connected and Convenient Care found here: https://www.ontario.ca/page/your-health-plan-connected-and-convenient-care

This process is intended to provide better coordination in the health care system and overcome silos that currently exist, as well as promote a better response to those with complex care needs through better follow-up and quicker decision-making. It intends to facilitate the Ministry of Health, Ontario Health, and Home and Community Care Support Services working together using stakeholder engagement to design the implementation of the new system.

The plan is also intended to introduce both structural and care delivery changes with HCCSS still currently responsible for Home Care, but it will be merging with Ontario Health to form a new entity Ontario Health atHome. This means that Ontario Health will be the new home for Home Care in Ontario. See also: https://news.ontario.ca/en/release/1003589/ontario-making-it-easier-and-more-convenient-to-connect-to-home-care

There is a lot of funding available for this modernization, and the Ministry wishes to ensure that it goes to the front-line.

The modernization process is legislatively supported by the passage of Bill 135 The Convenient Care at Home Act which consolidates HCCSS's 14 offices, staff and operations within Ontario Health, creating Ontario Health atHome – a subsidiary of Ontario Health that is intended to support system alignment and integration.

Ontario Health atHome is also intended to provide home care services until local Ontario Health Teams can assume responsibility for the delivery of Home Care; as well as provide long-term care placement and shared services to Ontario Health Teams; integrate care coordinators to work in new models within Ontario Health Teams; and improve the consistency and efficiency of home care delivery.

Ontario Health Teams are meant to integrate Home Care planning and delivery and spread new models of care delivery, while being supported by Ontario Health atHome provincially.

New models of delivering care, some of which have been launched over the past five years, are to include changes to how care providers communicate and make care decisions.

***Testing, Assessment, Spread of Useful Approaches***

Currently testing of new approaches is underway, as is assessment to determine how well they work, in order to facilitate the spread of useful approaches across the province.

The early emphasis of modernization was to target people ready to leave hospital considered to be alternative level of care patients (ALC). This was accomplished through a 16-week home and community care program (in person and virtual) to support their recovery and restore their ability to function independently. Transition planning to home started right away in the hospital.

One model of this is the Southlake Regional Health Centre working directly with home care providers to plan and support care decisions with added 24/7 phone support. Home care providers used teamwork and regular family and patient engagement to achieve the necessary support. The Southlake model combined the resources of HCCSS and the community support system. More information on this model can be found here: [https://southlake.ca/news/southlakehome-guide-for-health-leaders/](https://southlake.ca/news/southlakehome-guide-for-health-leaders/)

***Shifting Emphasis***

Emphasis is now shifting to better support people living in the community who need Home Care, especially frail adults meeting the criteria for long-term care who are waiting for an available bed who are either in hospital as ALC patients or at risk of becoming ALC patients.

Those with lower acuity (health needs of less seriousness and urgency) have not been an issue. It is properly serving those with more complex needs that has been challenging.

Until now providers have been paid per visit, but under the Ontario Health Teams model this may change, as Home Care is also to be better connected to primary care.

***Evaluation and Equity***

Evaluation of new models examines successful practices, patient outcomes, the patient and caregiver experience, system impact, and cost.

The goals of the system change are: to make care easier to access irrespective of where people live in Ontario; assist people to know what care they can get; fit care to peoples' needs including quick response to changing needs; make transition from hospital to home easier; ensure care teams are providing reliable, quality care; and make sure that Home Care is sustainable and funding is focused on care, not administration.

***Structural Changes***

In transitioning to Ontario Health Teams the structural changes are intended to improve access by enabling local knowledge and partnerships; advancing equity and standards across all OHTs using provincial program parameters; introducing new models of care led by OHTs and supported by OHT directed care coordinators to deliver more responsive care; by incorporating primary care the OHT care team is intended to create better transitions and connections for patients; new models are intended to support improved

care as well as better working conditions; with the assistance of centralized, well defined supports from Ontario Health atHome, more efficient care delivery is expected.

### *The Modernization Approach*

The Modernization approach engages partners, patients and caregivers with a focus on improving care in a balanced step by step process to minimize disruption to patients through careful planning; using front-line staff expertise to improve care; ensure equitable delivery of current and future care; facilitate engagement with, and input from patients, families, and caregivers; align with phased implementation of OHTs.

### *Ontario Health Team Acceleration*

There will be acceleration of Ontario Health Teams (OHTs) starting in April 2024 with each approved OHT receiving multi-year funding. 12 OHTs are currently being supported to advance quickly to this stage of potential designation for funding under the Connecting Care Act, 2019. These 12 teams are sharing lessons learned to support the readiness of all OHTs. The 12 teams are: All Nations Health Partners, Burlington OHT, Couchiching OHT, Durham OHT, East Toronto Health Partners, Frontenac, Lennox and Addington OHT, Greater Hamilton Health Network, Middlesex London OHT, Mississauga OHT, Nipissing Wellness OHT, Noojmawing Sookatagaing OHT, North York Toronto Health Partners.

### *Two-Pronged Approach*

In a two-pronged approach to the acceleration of Ontario Health Teams the focus is on supporting them to achieve **structural** and **patient-facing** milestones.

Structurally they are to create a not-for-profit corporation, establish a primary care network, standardize back office supports, and develop a home care readiness plan.

Patient-facing objectives are to put in place a standardized patient navigation solution integrating with Health 811, while implementing two or more integrated clinical pathways and continually working on signature initiatives that are tailored to the local population.

### *Audience Questions*

During the course of the session some audience questions could also not be fully answered because of time limitations. These included some of the questions that have been brought to SSAO most often by our members. SSAO will continue to communicate these priorities to the Ministry and Ontario Health.

This is a compilation of most of the questions that were asked via Chat or by participants in the session.

- **Will the direct funding program – Family Managed Home Care be expanded to include more older adults? This is also in line with other questions about financial support for caregivers.** The response was essentially – it's complicated. SSAO's interpretation is that other stakeholders, possibly service providers, are standing in the way of individuals and families becoming more empowered by being able to organize their own support and services. So the Ministry is attempting to balance these interests. There is discussion about where Family Managed Home Care "will live" (who will have jurisdiction for it) and how best to support equitable access to it across the province.
- **Are the new models of Home Care just focused on ALC patients and emptying hospital beds?** The response was that in the beginning that was the case, but things are now moving towards better models to keep non-hospitalized people at home.
- **How well do the new models improve continuity of care?** The response appears to be that with better coordination between hospitals, primary care, and home care this should improve.
- **Is the issue of wage parity for PSWs between hospitals, long-term care institutions, and home care being addressed?** Recruitment of staff was discussed and the Ministry's labour strategy, but there did not appear to be a clear response on this. There was discussion of the Ministry's wage extension program for PSWs found here: https://news.ontario.ca/en/release/1001056/ontario-extending-temporary-wage-enhancement-for-personal-support-workers Researchers have previously made the case for this - https://pubmed.ncbi.nlm.nih.gov/37695703/
- **Will the RFP process for home care contractors be opened since it has been closed for 16 years?** The response to this appeared to be that Ontario Health Teams will be looking at a variety of delivery models.
- **What happens after 16 weeks when someone leaves hospital and the initial support ends?** The response was that people will be transferred back to regular Home Care.
- **How will OHTs improve on the current design?** The response was they will focus more on improving population health and be more successful in developing partnerships locally. It was suggested that it is a big transition to have Home Care delivered locally because it has not previously been integrated in this way.
- **A question was asked about whether or not the move to OHTs would mean loss of existing management teams in HCCSS?** The response was a recognition that relationships have formed between service users and managers and that attempts would be made to maintain those. It appeared that this would be up to each local OHT.

- **There was a question in Chat about how it can be ensured that maximum effort and money goes to patient care if care providers and agencies delivering care are for-profit?** There was no clear response to this question.
- **How are early innovators selected?** This appears to be in response to the choice of 12 OHTs that are moving forward quickly. While no clear response was given to this question, during the presentation it was mentioned that these were the OHTs that were most advanced with respect to the structural and patient-oriented goals of the Ministry.
- **How are OHTs more accountable for integrated Home Care planning and delivery in contrast with the myriad of placeholder coordinator organizations Ontario has had over the past three decades?** Key goals with OHT in terms of improving on previous administrative arrangements were integrative care and care being delivered within communities. It was not clear on how OHTs will facilitate this in terms of actual mechanisms.
- **How are new models intended to improve the system's current delivery of continuing care?** While post-acute care represents a preliminary goal (presumably to address pressures on hospitals), the extended goal of better integrating home care with primary care seems to be the next step. There was no timeline for this.
- **What was missing from the various other previous organizations for home care delivery that required this "modernization"?** The response appeared to be that home care was previously in a silo and not integrated with the rest of the health care system, specifically primary care and hospitals. Modernization would address this.
- **Will this transformation be flexible enough to permit selected OHTs to trial acute hospital care at home for the general population?** There was no specific response to this question in Chat. SSAO will continue to seek answers about the expansion of Hospital at Home initiatives province-wide.
- **A concern was raised about the number of people with dementia being placed in LTC facilities because of pervasive and longstanding beliefs and practices among Home Care Coordinators that LTC is the best place for them. It was suggested that supports for people with dementia at home need to be focussed on activities of daily living assistance rather than just on personal care**. The response was that the presenters understand that LTC is not a viable option for addressing the increasing incidence of those living with dementia, and that they are working towards building different capacity in this regard. No specific reference to how they would address the current pervasive beliefs within Home Care that LTC placement is best, nor any reference to ensuring that expanding Home Care supports to include assistance with ADL's so people with dementia can remain living at home.

- **How will it be ensured that the end provincial objectives/goals in the quality of, availability of and delivery of home community care and support services are the same across Ontario, acknowledging that different OHTs might use different models for attaining the common provincial objectives/goals?** This question appeared to be answered in the body of the presentation giving Health atHome and Ontario Health this responsibility to ensure that there is equity.
- **Will OHTs located in designated regions under the French Language Services Act be mandated to provide services in French to the francophone population?** The response was yes, and the questioner was asked to contact the OHT in the specific areas to ensure that this is the case.
- **A question was asked concerning specific scenarios with respect to how a person's care plan gets adjusted quickly, where the primary care physician comes in, if house calls by family physicians and nurse practitioners familiar with the client/patient would occur?** Aside from a general response to this in the body of the presentation where primary care was being integrated into the home care modernization process, there was no specific response to this Chat question.
- **Will the OHTs all use the same communication platform to better increase access to care for people in the province and if not, why not?** There was no specific response to this question, but it may be the responsibility of Ontario Health atHome to achieve this through the new Service Organization outlined in an earlier SSAO mailing about Ontario Health Teams found here - https://www.seniorsactionontario.com/_files/ugd/50033d_5bcf8509c0934d4a9666f185606a5216.pdf
- **How will we evaluate the implementation of these changes?** There was no specific response to this question but the general statement is that Ontario Health atHome will have this responsibility along with Ontario Health.
- **How will you promote innovation without new health agencies?** There was no specific response to this Chat question. It appears that this decision will be up to local Ontario Health Teams.
- **Not hearing where palliative care at home fits into this plan?** There was no specific response to this Chat question, however SSAO will continue to pursue this question with the Ministry and Ontario Health.
- **What will happen while these new areas are opening up since there are so many areas that will not be getting the changes in the near future?** There was no specific answer to this Chat question that we heard.
- **There are many people who don't have a family doctor. What happens with ongoing care in the community?** Aside from the response that requests for Home Care still go to HCCSS, there was no specific response to this question.

- **How will availability of services be equalized across the province?** This was answered in the body of the presentation as a specific goal of modernization that was to be addressed by Ontario Health and Ontario Health atHome.
- **I've heard that the maximum 15 hours of service has been lifted. Is that correct?** The cap was lifted in 2014 in a Human Rights decision in a case brought by a mother with a disabled son. Here is the decision: https://www.ohrc.on.ca/en/cole-v-ontario-health-and-long-term-care-challenging-funding-limits-live-community-settings "The Ministry also agreed to recommend that CCASs be granted discretion to exceed the nursing caps in the regulation for those with "complex care needs".

**SSAO COMMENTS AND ANALYSIS**

This session was an information packed hour in which the framework of the Home Care Modernization process was shared with participants by the presenters.

SSAO did not receive permission from the Ministry to tape the session or to share the slides which is the reason for this synopsis.

Seniors for Social Action Ontario (SSAO) supports the goals of this modernization process, but has reservations about its implementation and some of the implications of this new process. These include: concern about wage parity issues of PSW's between hospitals, LTC facilities, and Home Care potentially not being addressed, the ability of OHT's to do a better job than what is currently in place; concerns about whether or not the Family Managed Home Care program will be expanded to more appropriately serve elders; and the possibility of more incursion of for-profit contractors into the Home Care mix.

In spite of it having been stated that there was an extensive engagement process that involved those receiving services and their caregivers, Seniors for Social Action Ontario - one of the largest seniors' advocacy organizations in Ontario - has never been invited to provide input to the Ministry or to Ontario Health – until now. We look forward to working with the Ministry and Ontario Health in providing useful information to them, and support for what we consider to be positive Home Care transformation objectives.

Because members of the audience asked the same questions about who was consulted, it appears that organizations with which they are affiliated were also not consulted. But those on the Minister's Patient and Family Advisory Council were consulted. Members of this Council are publicly appointed by the Minister under Section 10 of the Ministry of Health and Long-Term Care Act. A list of current members and a description of this process is found here: https://www.pas.gov.on.ca/Home/Agency/573

A consultation process that places an emphasis on hearing from Minister-appointed advisory committee members while ignoring other large stakeholder groups and organizations like SSAO is something we consider problematic.

It should be noted that it is the elected officials who create these policies, and the civil service (managers and staff of the Ministry of Health) who are required to carry them out).

***Accountability***

We are concerned about how "mature" OHTs will become and how quickly, how accountable they will be, and whether or not the government of Ontario will have adequate monitoring and accountability systems in place, including a health consumer feedback system, to ensure that they are living up to their mandates.

The current Home Care system is not accountable, and is top heavy with a senior management caste, some of whom are cut off from service user concerns and staff who provide direct care.  The Ministry appears to be aware of this problem as well as the barriers to teamwork created by the silos that have always existed between different sectors of the health care system.

At the present time it is unknown whether or not Ontario Health, even with the assistance of Health Quality Ontario, will be able ensure that this latest iteration of Home Care delivery will be more accountable to service users. Time will tell.

**SSAO Submission on Bill 135**

Many of our concerns related to Home Care Modernization and the creation of Ontario Health Teams have been outlined in our submission regarding Bill 135 found here: [https://www.seniorsactionontario.com/_files/ugd/50033d_f2c7f4cb2ed74780870cf163fa531fc2.pdf](https://www.seniorsactionontario.com/_files/ugd/50033d_f2c7f4cb2ed74780870cf163fa531fc2.pdf)

Many of these are policy issues over which the civil service has little control.  It is the Premier and his Ministers who determine what many of these policies will be and what the Act and Regulations contain. These include: the issue of wage parity for PSW's; the continued impact of profit making in Home Care; the failure to widen contracts to include more non-profit providers and the home care worker co-op; the removal of ordinary liability provisions against the Crown; riding roughshod over people's rights to confidentiality of their personal health records; allowing any person or organization to be designated an Ontario Health Team, which opens the door to possible corruption and patronage; and appointing a Board of political appointees to provide advice to the Minister about Home Care.  These are all issues with Bill 135. That Bill was proposed by those elected to the current Ontario government and is now law.

These and other serious issues, including how well palliative care will be integrated into Ontario Health Team service delivery remain a concern for SSAO that will be pursued in our advocacy efforts.

***What Can You Do?***

Since this shift to Ontario Health Teams is occurring, SSAO is advising our members to become actively engaged with the leaders of their Ontario Health Teams and to provide input to them. Here is a list of the Ontario Health Teams in Ontario by Region: https://www.ontario.ca/page/ontario-health-teams#section-2

Most have information on how to get in touch under "Contact".

SSAO would like to hear your experiences in contacting them. You can send your feedback to seniorsactionontario@gmail.com Once we have compiled a body of feedback, we will be pleased to share it with Ontario Health, the Ministry of Health, and Ontario Health atHome.

**Additional Resources for SSAO Members:**

The Role and Function of Ontario Health Teams (2022): https://www.ontario.ca/files/2024-01/moh-oht-path-forward-en-2024-01-22.pdf

Primary Care Networks within Ontario Health Teams (2024): https://www.ontario.ca/files/2024-01/moh-primary-care-networks-guidance-en-2024-01-23.pdf

Ontario Health Team Patient, Family, Caregiver Partnership and Engagement Strategy: Guidance Document (2021): https://www.ontario.ca/files/2024-01/moh-oht-pfc-partner-engagement-strat-guidance-en-2024-01-22.pdf

Primary Care Communications Protocol (2021) https://www.ontario.ca/files/2024-01/moh-oht-primary-care-comms-protocols-guide-en-2024-01-22.pdf

Ontario Health Teams Harmonized Information Management Plan: Guidance Document (2021) https://www.ontario.ca/files/2024-01/moh-himp-guidance-en-2024-01-22.pdf

Collaborative Decision Making Arrangements for a Connected Care System (2020) https://www.ontario.ca/files/2024-01/moh-oht-cdma-guidance-en-2024-01-22.pdf

Patient Family and Caregiver Declaration of Values https://www.ontario.ca/page/patient-family-caregiver-declaration-values-ontario