

ONTARIO NURSES' ASSOCIATION

SUBMISSION

ON

**Proposed Home and Community Care Regulations under
the Connecting Care Act, 2019**

TO

Ministry of Health

HCCB.Modernization@Ontario.ca

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The Ontario Nurses' Association (ONA) is the union representing 68,000 registered nurses and health-care professionals working in every sector of health care. Our membership includes thousands of Care Coordinators and direct care staff working within Home and Community Care Support Services (HCCSS) in almost every region.

ONA has spoken out at every stage of Bill 175, *the Connecting People to Home and Community Care Act, 2020*, including both the legislative and regulatory components. Our position remains that government must maintain the role of Care Coordinators and direct care staff. Quality home and community care must remain public.

We have reviewed the government's slide deck, *Update on Proposed Home and Community Care Regulations under the Connecting Care Act, 2019*. In our view, the proposals are inappropriate, untimely, unclear and untested. We strongly oppose the proposals to privatize care coordination as this would be detrimental to patient care, fiscally irresponsible and create a clear conflict of interest for Care Coordinators.

The government's proposals still do not provide certainty to ONA members on where their jobs will go, and there is no mention of many existing HCCSS job classifications including direct clinical services, rapid response, palliative care teams, mental health services, placement coordinators and administrative staff. We will also comment on what we believe are two gaping holes: funding and the health human resource shortage.

This submission represents both the analysis and feedback of our membership and local leadership regarding the proposals. Our message is clear: the way forward must be through building capacity in the public system. We urge the government to listen to this advice from the front lines.

Keep home and community care public

ONA's position is that government must protect the jobs and employment conditions of Care Coordinators and direct care staff in the public sector. This is the best way to ensure transparency, accountability and to protect the best interests of patients and to prevent fragmentation of care and inconsistency throughout the province.

We recommend that government maintain four to five independent agencies that function as an umbrella agency for home care services. These would remain Crown Corporations, funded publicly by the Ministry of Health, providing the patient-care services formerly provided by the Local Health Integration Networks (LHINs). This would allow for Care Coordinators and direct care staff to remain independent, at arm's length from the service providers, profit and funding. In addition, it would allow for continued consistency, structured support for the Care Coordinators and standardized oversight of care regardless of location in the province.

Our members who work as Care Coordinators are regulated and/or registered health-care professionals. They put their patients at the centre and describe their work as an actual artform that requires many years of experience and extensive knowledge of local health care and support services. Our members also report that due to the COVID-19 pandemic, cases are more complex, and patients are frailer and sicker than ever before. Patients are being discharged from hospital at times more quickly and often without a plan in place. Care Coordinators must act quickly to ensure services, medical equipment, medication and supplies will be in place in order to avoid rehospitalization. The last thing that is needed in the health-care system in Ontario is significant destabilization.

In ONA's view, it is chaotic to vision the Care Coordinator role moving to Ontario Health Teams (OHTs) as we do not see any ability to ensure consistency with respect to available services or access to Health Service Providers when there is a potential for there to be more than 80 OHTs. What will be the provincial requirements for Care Coordinators? Who will monitor this?

Some of the approved OHT's have more than 100 partners that do not cover all potential services that may be required in any given geographical area. Huge portions of the province remain without approved OHTs. Indigenous services are limited with no clear plan to integrate such services into any OHTs. Few OHT's have home care services as one of the named partners. It is difficult to see how care will be seamless in all areas of the province with the same levels of care no matter where one resides. This is not in the public's best interest.

ONA's recommended proposal would keep Ontario Health as is, and allow for all existing HCCSS staff as well as front-line workers in home care delivery to operate under a new umbrella agency – this would decrease fragmentation and increase consistency by keeping the function at the same level across the province. This would also ensure that home care services and service providers remain publicly funded, monitored and delivered through a single source and not parsed out to various for-profit providers for each service required.

All appeals and complaints could still be funneled through an Ombudsman role to this level for intervention, investigation, feedback and follow up. This would remove the perception that complaints are received by the care provider and not necessarily reported or responded to as they are the caregivers as well. This also ensures that a level of quality assurance review can be conducted at the “umbrella agency” level allowing for amendment, adjustment and ongoing revision of the plan of care in a dynamic and responsive manner.

For years, ONA has advocated to integrate care coordination and home care delivery under a single public employer. We believe that eliminating the Request for Proposal (RFP) system, the management of contracts and all for-profit care delivery in home care

will provide savings rather than public funding going to private profits. The savings from managing the RFPs could then be redirected to provide home-care staff with good jobs – full-time jobs with competitive wages and benefits. This is essential for both recruitment and retention in this sector.

Home care is a critical health service for communities and people. The need will only grow as our population ages and patients seek to live a dignified life at home until placement in a long-term care facility is required to meet their needs. We urge government to change course and promote quality, public home care services for all who need them in Ontario.

Integrity of public health care, expanding profit-making and the Canada Health Act

ONA strongly opposes the government’s proposals to contract out Care Coordinator jobs, opening the door to more profiteering in home care, potential conflicts of interests for health-care professionals and a significant loss of public accountability:

- Slides 8 and 14 of the government’s slide deck confirm that the new regulations will permit care coordination work to be contracted out to home care agencies, many of which are for-profit.
- Slide 15 says that the Health Service Provider would “assign a degree of care coordination responsibilities... to its contracted providers to ensure care remains responsive to client needs.”
- Slide 19 lists the criteria by which care coordination functions could be assigned to a contracted service provider and profit is not a limitation.

These measures will lead to privatization of significant portions of the existing public components of home and community care, undermining important tenets of the *Canada Health Act*. Our members want to know: Who are the for-profit Care Coordinators accountable to first – the patients, government, or their shareholders? Who will provide the oversight for quality and value for money? Where is the evidence that for-profit providers have been able to show fiscal responsibility?

Our members want the government to explain how is it possible to assign a “degree of care coordination”? They believe that it is either all or none. If this role is incorporated into other duties, it gets lost, fragmented and the patients will suffer.

Our members who work as Care Coordinators in the current system are all regulated and/or registered health-care professionals. If Ontario transitions to a for-profit system, will Care Coordinators have the same level of education, experience and

professionalism? Many for-profit Health Service Providers employ “Care Coordinators” to assign available services without the qualifications or experience required of the current HCCSS Care Coordinators – they hold the title without the credentials.

Time and again, ONA members have flagged that the government’s proposals, if enacted, would require Care Coordinators to conduct assessments for patient care plans delivered by the same contracted providers for whom they work. This dual role creates a serious conflict of interest, especially when profit-making is involved. If a service provider can order the services they provide and then charge the government or patients, there is great potential for self-interest to distort service delivery and unnecessarily drain resources.

Our members can point to numerous examples of existing pilot programs where the government is funding for-profit providers who do an additional assessment using a similar Care Coordinator model. This includes funding “bundles” assigned to private service providers who struggle to provide care to patients in a race to use the allocated funding within a 12-to-16-week time frame.

Patients in these pilots are front-loaded with services that are often unnecessary but provided by the same program and it is then reassigned to HCCSS Care Coordinators when the program ends because the patients are not able to be discharged without supports within their homes. HCCSS is forced to reassess the patients without the benefit of interviewing and assessing them in a hospital system with access to their hospitalization records or records of the care provided by the private providers during that 12-to-16-week period. One of the great strengths of the existing HCCSS system is the common e-documentation platform that allows sharing of patient records across HCCSS locations and within care providers. This strength is at risk of being lost.

Moreover, this is a duplication of work that does not promote independence of patients and sets them up to expect services that are not really needed. It further requires the patients and their families to describe the care they received, what worked and what did not as well as what they could not obtain that would have made their recovery a reality rather than leave them dependant longer then necessary.

Our members also say that other care providers, such as physiotherapists, must be pushed to prove that they have met the patient needs and that they are not charging for unnecessary services or visits they are not attending.

Under these pilots, where is the public accountability structure? When care coordination is not done by a separate entity, there is no accountability and no “checks and balances.” Our members are advocating for their patients who will suffer as there will be no one to

ensure service is delivered and the quality of that service. Removing Care Coordinator roles from the public sector will be disastrous for patient care.

Finally, our members also raise the concern that many of the same for-profit agencies in home care are operating in long-term care where they have reported far more COVID-19 deaths on average than non-profit and municipal facilities. For instance, ParaMed is owned by the for-profit long-term care chain Extencicare. The government must apply the lessons from COVID-19 and put care over profit.

The future of direct care teams

It is a major cause for concern that our experienced members are retiring, leaving or taking leaves because of the uncertainty surrounding where their employment (including compensation, pension and union representation) will be transferring to, or whether they will have to apply to new positions. The restructuring process continues to be a massive source of uncertainty and anxiety.

We are particularly concerned that the proposals are silent regarding our members who work as part of direct care teams. This includes direct clinical services, rapid response, mental health services, palliative care teams, placement coordinators and administrative staff. What is the plan for these positions?

Slide 14 mentions integration with “primary care”, specifically “integrated care delivery and improved referral networks.” Our members are concerned that if they are absorbed into the primary care system this will be devastating to the specialized care they provide and further erode the public system. They are concerned that they will not have the level of support needed to ensure that patients receive the care they require versus what is available.

What will happen to the most vulnerable patients, especially those who do not have a primary care physician/provider? These unattached patients will use the emergency room for care or avoid seeking medical attention until they are so ill that they require hospitalization thus costing the health-care system more than if they had proper follow-up on initial presentation to emergency or first discharge from hospital.

In addition, the crisis in long-term care is top of mind for most Ontarians but the proposals do not include a clear plan for placement coordinators. ONA’s position is that these positions should stay with home care coordination to maintain that continuity of care as seniors and others transition from home care to long-term care.

Once again, our members are urging the government to utilize the existing staff and resources in the public system. Our members know their areas, the types of patients they work with, the available services and care that they need. Protect their jobs and keep

home and community care public. Unnecessary uncertainty in these times of COVID-19 and during the catch up of health-care services will only result in further confusion, hardship and inefficiency.

Failure to address the funding shortfall and shortage of human resources

It is not possible to reform home and community care without addressing the severe staffing shortages. Therefore, it is a major concern that Slide 8 promises to eliminate service maximums without any plan or budget to hire more health-care professionals either in the existing HCCSS or home care providers.

As our members have raised in previous consultations, the cash-strapping of the sector – reflected in the low-wages and poor working conditions – continues to contribute to the retention and recruitment crisis. ONA members note that under current funding pressures, service maximums are in place simply to ensure the fiscal sustainability of the system. Moreover, the de facto service maximum is more often mediated by shortages in the supply of health-care workers, not legal requirements.

For example, VON Thunder Bay and District is unable to recruit and service community home care needs in the Geraldton district. In response, the Northwest HCCSS has approached the Geraldton District Hospital to assume the contract temporarily and provide the services.

There is a similar situation in Atikokan where the hospital is creating a full-time nursing home care position for their area. The service provider, ParaMed, has had major issues with staffing and turnover that is negatively impacting the ability of patients to receive home care. Waitlists are more than 60 days for basic home care and other services in many areas of the province. These are just a few examples of many taking place province wide. Where is the plan and funding for health human resources?

As previously mentioned, opening the door to further privatization, including private assessments by private companies to benefit themselves and their own profit, does not assist with scope of service or service maximums. At a minimum, there needs to be guidance and support on service maximums and clear definitions not only on what services will be provided, but the scope of those services. Assurances need to be in place to ensure there is not overlap of services provided by family health teams, mental health organizations, hospitals, the Alzheimer's Society, and similar organizations.

Our members also are requesting that government detail how there will be equity in the services that patients receive looking at the social determinants of health, and other available resources in communities. Research consistently shows that poverty and low-

income status are associated with various adverse health outcomes. How will government ensure that patients who are vulnerable and/or living in poverty are able to get the care that they need?

ONA's position is that the government must create a positive right to meet patient needs for home care, matched with at least inflation-adjusted increases to home care funding and guaranteed decent working conditions and compensation. This would do much more to improve service quality for patients than the arbitrary removal of service maximums.

Weakened democratic and public accountability

Slide 21 proposes to enshrine in regulations a Bill of Rights for home care recipients in regulations, "modelled on the current Bill of Rights but updated to be more inclusive and comprehensive." It remains ONA's position that putting the Bill of Rights into regulation rather than in law is a downgrade and allows it to be amended more easily with little public awareness. However, some of the proposed language that is proposed does appear to improve the quality of the rights of home care recipients, including granting access to their care plan and preventing discrimination under the Ontario Human Rights Code.

Slide 28 references a new process for complaints, including new requirements around shorter response times and accountability measures for the service provider in treating complaints. Our members want to see complaints go to an independent agency that has no conflict of interest. Hospitals have third party advisors, and there should be a similar model for HCCSS as well. Those receiving the complaint should have no vested interest in the outcome of investigations. Those who raise complaints should not fear reprisal.

Our members also have concerns about how the proposed complaint process will fit with accountability requirements under their professional colleges. Care Coordinators have accountability as patient advocates to ensure assessment and care is provided as needed.

Finally, slide 10 proposes the introduction of "a new group (Indigenous Services) that includes Traditional Healing and Indigenous Cultural Support Services." ONA's position is that there must be meaningful consultation with Indigenous communities, including at the local level, prior to enacting these programs.

Conclusion

ONA members and its leadership are urging the provincial government to change course immediately and promote quality, public home care services for all who need them in Ontario. There is no advantage to further privatizing home care and eliminating valuable

Care Coordination in a publicly funded health-care system. As well, the quality, scope and dignity of care at home and in the community will be undermined. We must promote a system that protects against unnecessary hospitalization or admissions to long-term care homes.

We are calling on the government to adopt our recommendation to maintain four to five independent agencies that function as the umbrella agency for home care services. This would allow for Care Coordinators and direct care staff to remain independent, at arm's length from the service providers, profit and funding. It would also allow for continued consistency and standardized oversight of care. This is the best option for patients who depend on the full scope and experience of Care Coordinators and direct care teams.

ONA members and its leadership are committed to working collaboratively with the Ontario government to improve home and community care for patients and workers alike. It is crucial that the Ontario government get reforms to this sector right to build a stronger home care system for tomorrow. Ontarians are counting on it.