Ontario Society of Occupational Therapists

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Amy Olmstead
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Ministry of Health

Delivered via e-mail HCCB.Modernization@ontario.ca

Dear Ms. Olmstead,

OSOT feedback on proposed Home and Community Care Regulations under the *Connecting Care Act, 2019*

The Ontario Society of Occupational Therapists (OSOT) appreciates the opportunity to review the updated proposed regulations under the *Connecting Care Act, 2019* which are developed to advance modernization of the province's home and community care services.

Occupational therapists provide occupational therapy services across the breadth of the publicly funded health care system - primary care, acute care, rehabilitation, home care, long-term care – and have long advocated for service delivery models that more are truly client-centred and effectively facilitate transitions and minimize barriers to a flow of care that follows a patient's journey through the health system. Further, occupational therapists have identified both the need and opportunity to benefit both patients and the health care system by providing upstream services targeted to maintain health and well-being and to support and enable people to manage well in their homes and communities for as long as possible. Our 4800 members extend support for system change and regulation that can position home and community care services to best serve these objectives.

Our comments are forwarded in support of development of a home and community care system that can be well integrated into the proposed transformation of Ontario's health care services delivery

1. Scope of Services/Service Maximum (slide 9 – 11)

- OSOT appreciates the messaging that we infer from the proposed framing of services as professional, personal support services, homemaking, community support services and indigenous services under the umbrella of home and community care services. This addresses concerns and recommendations we have previously made to remove an intentional focus on the provision of "care". We believe this framework more effectively underlines the diverse roles the home and community care system may play in a more integrated health system.

- *Indigenous Services* - The addition of Indigenous Services is important. While this appropriately brings culturally appropriate services accessible to indigenous clients, policy guidance may be required to support and assure that other services that may be provided are informed and integrated to be complementary.

- *Psychological Services* - The addition of psychological services was supported by OSOT in the 2020 consultation however, it is unclear whether there has been a shift in thinking relating to the use of psychological services. In the 2020 regulation consultation, "psychological services for persons with acquired brain injury" was proposed. We note that the current proposed eligibility criteria is that a "person has a long-term mental health disability or responsive behaviours". It is not clear whether this introduces the notion of counselling or psychotherapy for persons living with chronic mental illness for example. If so, the Society would position that several mental health professions, including occupational therapy, have the scope and authority to provide these services. In light of the need to address equity of access and system capacity, if mental health services or psychological (counselling/psychotherapy) are to be provided to eligible clients, policy should direct that all regulated mental health professionals (OT, Social Work, Psychology, Nursing, Regulated Mental Health Professionals) could be providers.

  Occupational therapists' work with clients focuses on the whole person and the inter-related impacts of their health status and abilities, their environment and the occupations that they need and want to be engaged in. Mental health is a part of who each client is and is difficult to separate from chronic disease, disability, aging or other conditions that may create needs for home and community care services. Our profession is hopeful that health system transformation will more effectively integrate mental health services targeted to meet client needs with other services they may be receiving. The absence of any specific discussion of mental health or addiction needs is glaring in this discussion of home and community care.

- *New Community Support Services* - The proposed new community support services are supported. The breadth of community services that may be provided underlines a critical need for integration of care plans to avoid duplication of effort in those cases where a professional services provider may have scope and competency to provide similar services – e.g. behavioural support, psychogeriatric consulting services, independence training, palliative care. For example, in many jurisdictions occupational therapists are members of behavioural support teams addressing needs of clients with dementia and responsive behaviours and/or palliative care teams that provide team-based care from the point of diagnosis/prognosis to end of life care. These are important contributions to protect to maintain quality of service provision.

- *Independence Training* - Occupational therapists who reviewed this material were not aware of the specific nature of "independence training" and queried whether there were linkages to the provision of occupational therapy services which focus on promoting skill and ability to improve independent functioning.

- *Training* - Occupational therapist who reviewed this material questioned the listing of "training a person to provide any of these services". It is not clear what this refers to. Professionals providing services listed as professional services would not be trained to deliver their services on the job. Does this relate to service provider organization orientation?

- *Removal of Service Maximums* - OSOT continues to support the removal of service maximums and a move to more needs-based, individualized approach to care. We assume this decision applies to all services. Service maximums, in the shape of visit maximums, have significantly limited the scope and efficacy of occupational therapists in the home and community care system resulting in more limited potential for clients to achieve goals and for the system to see real value for money. When service maximums (visits) are unreasonably limited, the limitations on the comprehensive quality of services delivered puts both the client and the regulated occupational therapist at risk.

  Currently, OSOT members report variable service maximums for OT services depending on where a person lives. Further, policy direction about how maximums are utilized can vary. For example, OTs can receive referrals for 3 – 7 issues but only be allocated a service maximum related to one. Trying to address 7 issues in the 3 visits that are allocated to one is impractical. These conditions are both unsupportable and inequitable.

It will be important to assure that there are clear measures to ensure that the client and family/caregiver voice inform access to services. This recognizes that each client is unique in their physical, cognitive, emotional and functional status and deals with a unique living environment and support system. Perhaps more importantly, individuals find meaning and quality of life in different ways that are important to respect. We believe that meaningful client engagement contributes to commitment, recovery and problem aversion. Several community-based programs employ the Canadian Occupational Performance Measure (COPM), which measures performance and satisfaction in self-care, productivity and leisure from the client's perspective, as an outcome measure.

Notwithstanding our enthusiasm for needs-based approaches, policy guidance will be required to ensure delivery of services, while more person-centred, will be equitable across the province and that client and family expectations are managed. OSOT would be pleased to consult on this policy evolution.

2. Client/Patient Eligibility Criteria (Slides 12 – 13)

- We note the question/concern for clarity around the eligibility criteria for access to psychological services mentioned above.

- *School-based Rehabilitation* - The Society has previously identified a query relating to school-based rehabilitation services. We have understood that school-based OT services for those students in private schools or those who are home-schooled continue to be funded through Home and Community Care, notwithstanding school-based rehabilitation services to public school boards are funded and delivered through the Ministry of Children, Community and Social Services. OSOT may be unaware that there is clear guidance on this, however, it is not evident in the proposed regulations.

- OSOT supports the eligibility criteria that persons need the service to facilitate a return home from hospital or another institution or to remain in their home and that the service is reasonably expected to result in progress towards rehab, maintenance of functional status or palliation. Occupational therapists would assert that these criteria can and should be interpreted to include health promotion and prevention of deterioration or risk. While these are current criteria, they are not typically used to address these proactive issues which become paramount in a health system aiming to enable older adults to age well and safely in their homes.

3. Care Coordination (Slides 17 – 20)

- OSOT continues to support the proposed objectives of the new regulations for care coordination and the flexibility a future more integrated health system will have in placing care coordination where it makes most sense and enables timely changes responsive to client needs

- *Requirements for Care Coordination* - The new requirements for care coordination (page 17) are deemed to support the patient experience by reducing duplication of assessment and are generally supported. Attention to the broad determinants of health is critical to address in a health system more focused on health promotion and maintenance of health and wellness in addition to the provision of restorative and care services.

- The requirement to have outcome focused goals with planned amounts, duration and modalities of service suggests that frontline clinicians are developing such plans based on their clinical assessment of the client. OSOT agrees that this is entirely appropriate, recognizing that patient progress and reassessment may result in revision of the plan based on clinical evidence. Regulated professionals are accountable for the development of treatment plans based on assessment and consultation with the client.

- There is concern that care coordination could be formally downloaded to the frontline clinician. This is occurring increasingly even in today's home care system where roles previously assumed by care coordinators such as connecting clients with other community resources, supporting families, extending the clinician's responsibility for security checks when a client is not answering for a visit, etc. are expected of frontline clinicians such as OTs. This results in additional uncompensated work. Wherever care coordination occurs in a future system it must be fairly compensated as such and not assumed part of frontline provider's role.

- *Patient Engagement* - While there are several references to engagement of the client in relation to care coordination – ensuring they receive assessment results and care plans in formats accessible to them, consideration of the client's preferences, etc. – there is no specific reference to the need to develop goals, care plans, etc. *with* the client. Occupational therapists would advocate for explicit inclusion of this requirement of patient/client-centred care which is referenced in the Patient Bill of Rights. Developing plans in collaboration with the patient is not only best practice but also promotes

patient education, trust, patient commitment, etc.

- *Factors to be Considered* - Identified factors to be considered in the development of a care plan (page 18) are all important. OSOT would assert that the responsibility for professional service treatment plans which are integrated into the care plan must rest with the regulated health professional providing the professional service.

- *Team communication* - On page 18 it is noted that "providers would be required to seek to coordinate their care delivery with other providers to avoid duplication and ensure quality of care". OSOT supports the value and best practice behind this statement, however, if frontline providers are expected to coordinate their care and communicate with other providers funding models must pay for this time. In today's home and community care sector, this critical element of interprofessional/team communication is not compensated for professionals who work on a visit-based payment model that compensates professionals only for their direct time with a client. This critical factor needs to be addressed.

- *Client Preferences* - The consideration of a client's preferences based on ethnic, spiritual, linguistic, familial and cultural factors is not a new factor and is also enshrined in the proposed Patient Bill of Rights, both. OSOT values and supports this commitment, however, recognizes that client expectation may need to be managed relative to a region's capacity to respectfully meet a client's preferences. The profession of occupational therapy, for example, is working to increase its diversity and capacity to serve the significantly diverse populations of Ontario, however, our profession is small and will be challenged to deliver to the standard we aim for. The Ministry is encouraged to promote recruitment initiatives to support and engage under-represented groups to enter health professions.

- *Potential Conflict of Interest* - OSOT supports the proposed flexibility for Ontario Health Teams (OHTs) and Health Service Providers to assign care coordination to contracted organizations bringing care coordination closer to the frontline and reducing duplicative assessments and care planning. It is presumed that policies will address processes to mitigate any potential for conflict of interest that could exist if a contracted provider organization also houses care coordination. It would seem that there could be the potential for perception of conflict of interest when service volumes are determined by assessed need not visit maximums.

- *OTs as Care Coordinators* - The Ministry proposes a staged implementation plan for transitions in care coordination which is supported. The sector is currently well served

by experienced Care Coordinators and it would be unfortunate to lose access to these skills, experience, and wisdom as care coordination shifts to different organizations. Occupational therapists are among these experienced Care Coordinators and bring a unique background in both physical and mental health and a practice focus on enabling occupational performance in the context of one's environment – managing the day to day living skills germane to remaining in one's home and community. The wholistic focus and attention to the physical, cognitive, mental health and social factors contributing to a person's health positions them to be ideal care coordinators. In developing policy the Ministry should ensure that occupational therapists are amongst those eligible to be Care Coordinators.

4. Bill of Rights, Location of Services, Eligible Providers, Methods of Delivery - 21 – 25

- *Bill of Rights* - OSOT fully supports the proposal Bill of Rights

- *Location of Services* - OSOT fully supports the provision for home and community care funded PSWs in long-term care homes to support transitions of persons with behavioural issues but has concerns about the prohibition of home and community care services in hospitals.

  Although the Society would support a principle that duplication of service be avoided, we point out that in some cases, enabling an overlap of hospital and home care professional services truly serves the health system, its flow and the patient's health care journey experience. Occupational therapists are important participants in enabling successful discharges from hospital to home/LTCH. In some regions, protocols enable a home care OT to conduct a pre-discharge visit (1-2 visits) in the hospital to participate in the discharge planning process, to assess the client's needs in the home, and to facilitate the readiness of the home (caregiver education, home modifications, equipment/assistive devices, etc.) for the client upon discharge. Removing the capacity to provide this service would seem counter-intuitive to the development of a truly integrated health system. OSOT recommends that provisions be retained to allow this type of access for home care OTs.

- *Eligible Providers* – OSOT understands the proposed regulations would allow Ontario Health Teams or Health Service Providers (hospitals, FHTs, Mental Health Centres, etc.) to provide home and community care services either directly through their employees or indirectly by contracting to not-for-profit and/or for-profit providers. This flexibility is of real interest to occupational therapists. Occupational therapists are engaged primarily in the home and community care sector as independent contractors

contracted by service provider agencies. These workers have no security of employment, no paid benefits or vacation, often significantly variable work volumes from week to week, and are paid at levels that positions even experienced OTs in the sector amongst the lowest paid OTs in the province. Occupational therapists are paid on a per visit basis for time spent in direct client care and are not compensated for the extensive indirect treatment time spent sourcing mobility/home safety equipment, funding sources, reporting, communicating with family physicians or other team members, etc. The potential to see therapy services provided under a HSP employment model, with compensation and benefits equivalent to OTs already working in that HSP, would create a more competitive home care system that is able to attract and retain experienced therapists which is so critical in an independent practice model such as home visiting community-based services. To this point, OSOT would position that professional service provider agencies contracted by Ontario Health or an OHT could also provide employment models if contracts provided the fiscal resources to do so. We project the investment in employment models would reap returns and value for money in skill level/competence, innovation, quality improvement, etc. – higher quality care and better client outcomes.

- *Methods of Delivery* – OSOT supports regulations that provide for flexibility in providing services in-person or virtually, as long as the services support quality care, are appropriate, are based on assessed need, are in line with the person's preferences, and are deemed to be of equivalent value in terms of compensation models. OSOT would assert that treating professionals must determine, in consultation with their clients, what delivery method is most appropriate and in line with the client's preferences. Hybrid models should be supported when appropriate, these may introduce real savings when some routine aspects of a care plan can be delivered virtually (without travel costs) to complement components that must be delivered in person. The pandemic has provided real evidence of how appropriately used virtual care services can support service efficiencies and the ability to serve clients in more remote areas.

5. Residential Congregate Care Services

- The Ontario Society of Occupational Therapists is interested to participate in consultations regarding the provision of health care services in residential congregate premises. Occupational therapists currently provide services to clients in retirement homes, shelters and social housing.

OSOT does not have specific comments on other components of the proposed regulations.

We review with enthusiasm the potential for a home and community care system that is positioned to be truly integrated within and with OHTs or other health service providers. We applaud the commitment to more effectively direct policy to support person-centred care, engaging the client to both identify his needs and to achieve and/or maintain his health goals.

While the changes will take place over time, the change is significant. We share our profession's concern that the sector is presently weakened by challenging human resource issues, issues that need to be addressed to bolster the sector for adaptation. We believe that occupational therapy is but one example, but we share the OT profession's experience which currently reflects a challenging vacancy rate across the province, high levels of turnover when more stable job opportunities come along, hiring practices that have had to focus on new graduates that bring entry level competence but little to no community experience to their work which is largely independent home visiting. As they develop skills, these new community providers leave for more secure employment. As mentioned previously, the experience of precarious employment and lack of visit fee increases over many years has left the sector a poor sister to other opportunities that are expanding for occupational therapists. This is resulting in high vacancy rates, challenges to recruitment, and long wait lists for services. We urge the Ministry to address these human resource issues to ready the sector for modernization and change. To this end, the Ontario Society of Occupational Therapists would be pleased to contribute to solutions-focused discussions.

Should there be a need for clarification of any of our points, please contact Christie Brenchley, Executive Director at cbrenchley@osot.on.ca/416-322-3011.

Sincerely,

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