Ontario Society of Occupational Therapists

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Amy Olmstead
Director, Home and Community Care
Ministry of Health

Delivered via e-mail

Dear Ms. Olmstead,

OSOT feedback on proposed new regulation under the *Connecting Care Act, 2019*

Thank you for the opportunity to review proposed changes to Ontario's home and community care program that through regulation development will support the *Connecting People to Home and Community Care Act, 2020.*

Occupational therapists are key rehabilitation professionals who are engaged and funded through the existing home and community care program. Their insights and comments have been sought to inform this submission. As occupational therapists provide necessary services to clients across the breadth of the publicly funded health care system (primary care, acute care, rehabilitation, home care, long-term care) the profession offers perspectives that relate to how home and community care services are positioned and integrated with other components of the health system

Our comments are forwarded in support of development of a home and community system that can be well integrated into the proposed transformation of Ontario's health care services delivery. Rehabilitation services are essential to a client-focused, integrated care system that supports seamless transition throughout an individual's health care and aging journey. The *Connecting People to Home and Community Care Act, 2020* provides a legislative backdrop for the more effective integration of services into Ontario Health Teams or other integrated models.

It is understood that the intent is to repeal the existing *Home and Community Care Act, 1994* at some point in time. It is not clear where the purpose and goals of home and community care services will be articulated or enshrined. OSOT suggests that the integrated system of the future would be best served if there was clarity for the mandate and purpose of home and community care services. While these may be articulated in the mandate and goals of Ontario Health Teams, we believe this issue is worthy of policy review and consideration.

Community rehabilitation has been shown to be an important contributor to system flow, timely discharge from hospital, prevention of readmissions and emergency department visits and promotion of ability of individuals to maintain a quality of life and manage their health conditions in their home as long as possible. Despite this knowledge and experience in many jurisdictions, access to rehabilitative services in Ontario's home care program has been minimized over the years, replaced with a focus on caring for clients through the provision of personal support and other community services. While many clients will need to rely on such services, many have potential to increase their level of functional independence and engagement in life occupations that are meaningful for them – self care, home management, social interaction, community participation, etc., and, in fact, reduce the need for personal support or facilitate caregiving by family or others. OSOT has long advocated for a more enabling focus of home and community care. We believe that there are good jurisdictional examples of such and that this is a critical time to enshrine a rehabilitative/enabling/restorative focus to the provision of community-based health services.

The following presents OSOT's feedback to each section of the Ministry's consultation document.

Scope of Service

Proposed amendments to the *Connecting Care Act, 2019* would use the term "home and community care services" and would provide the Lieutenant Governor in Council with the authority to further define these services in regulation. The ministry is proposing to maintain the "community services" outlined in the *Home Care and Community Services, 1994* and *Ontario Regulation 386/99* as home and community care services as they are deemed to be appropriate and in line with other jurisdictions.

The ministry is also seeking feedback on the following changes under consideration:

- **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".**
    - **Home care services would comprise: professional services, personal support services, homemaking services where personal support services are also provided, security checks and reassurance services where other home care services are also provided.**
    - **Community care services would comprise the remaining services listed in the *Home Care and Community Services, 1994* and *Ontario Regulation 386/99*, including personal support services, homemaking and security checks and reassurance services.**
    - **The proposed inclusion of personal support services, homemaking and security checks and reassurance services as both home care services and community care services is deliberate.**
    - **Education, training and the provision of supplies and equipment related to the provision of home care and community care services would also be included in the list of services.**

- While we understand the challenge of "labels", OSOT will take this opportunity to underline the common use of the word "care" for both home care and community care services.

  Terminology in the *Home and Community Care Act, 1994* speaks to a purpose of the act to "integrate community services that are health services with community services that are social services in order to facilitate the provision of a continuum of care and support;". The notion of health services as distinguished from social services is lost in the proposed definition of Home Care Services and Community Care Services. While not intended, adopting the word "care" for health and social services may rightly be interpreted by the public as the provision of care and supports for being cared for, informing and reinforcing public attitudes that the publicly funded home and community care system provides for a right to be cared for as one experiences barriers to independence that result from health issues or aging. We would argue that particularly as the Ministry works towards integration of home and community services to support the whole health system better, that it is important to ensure that "caring for" someone is not seen or interpreted to be the only role and purpose of the home and community care system.

  We note the list of services included in the proposed Community Care Services and question whether these are "care" services (providing care) or "support services" (supporting people to live in the community. Would Community Support Services be a clearer title?

  We note that Home "Care" Services does not adequately address the scope we hope an integrated home and community care system will have and does not reflect the rehabilitative, restorative or enabling goals of treatment and health care provided by health care providers in Home Care Service. Would Home/Community-based HealthCare be a more accurate label?

- It has been the Society's position for many years that our home care system has increasingly focused almost solely on the provision of care (Personal Support). The provision of therapies over the years has been minimized. Home Care Ontario reported that in 2015/16 the percentage of home care visits were allocated in the following manner;
    - 74% of care delivered was personal support / homemaking
    - 21.5% of service was nursing (shift and visits)
    - 4.5% of visits/hours were provided by therapy providers

  OSOT suggests that positioning our home care system to be more enabling would be strategic as we move to more integrated care models. Home/Community Healthcare could broadly focus on health and well-being, including rehabilitation focused on restoration of function post health incident or impacts of aging or chronic disease, prevention of health incidents (falls, pressure wounds, etc.), maintenance of abilities as long as possible safely at home, monitoring of chronic diseases, etc. These foci facilitate

timely discharge from hospital, prevent admissions, ER visits and minimize care demands.

We note that at a federal level there is more explicit commitment to a home and community care system that *"assists people to remain as independent as possible"* and "*help[s] people stay at or return home and receive needed treatment, rehabilitation or palliative care* ...". The government of Canada articulates the goals of home and community care to:

- Help people maintain or improve their health status and quality of life,
- Assist people in remaining as independent as possible,
- Support families in coping with a family member's need for care,
- Help people stay at or return home and receive needed treatment, rehabilitation or palliative care, and
- Provide informal/family caregivers with the support they need.
- Retrieved from Government of Canada Home and Community Health Care website.

- External to the purview of this consultation is the relationship of home and community care services and supports with the province's mental health and addictions services. 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 noted discussion of mental health or addiction needs is glaring in this discussion of home and community care.

The ministry is proposing to add four new community care services that are currently being provided by Local Health Integration Networks (LHINs) but are not captured under the current framework:

- **Aphasia services**
- **Pain and symptom management**
- **Diabetes education**
- **Psychological services for persons with Acquired Brain Injuries**

- OSOT can support these inclusions as they address important needs. This notwithstanding we note that these programs appear to contradict statements included in the scope of service section above which identifies the inclusion of profession services in Home Care Services, not Community Care Services. It would our expectation that regulated health professionals would be involved in these proposed new services and that their services might well be considered "treatment".

- We query whether the notion of identifying services such as the 4 proposed may expand as Ontario Health Teams emerge and view the opportunity to provide a "service" across a system. For example, using an example relevant to OT practice, Seating and Mobility services increasingly require an expertise that is difficult for every provider to maintain. It could be that an OHT looks at the cost-efficiencies and cross sector practicalities of have a Seating and Mobility Service that engages OTs and other necessary health professionals and stakeholders to work across a range of practice settings – primary care, hospitals, homes, long-term care. Is this type of evolution enabled in the proposed regulation development?

- OSOT queries whether Palliative Care should be added as an interprofessional community care service. While we note that palliative care education and consultation are listed as community services in *Regulation 386/99*, best practice would speak to an interprofessional/coordinated approach to palliative care which would speak to the coordination with nursing, personal support, occupational therapy, physiotherapy, speech language pathology, etc. as may be necessary to support the palliative needs of a client.

- We identify the need to ensure that policy and funding formulae enable interaction of providers in these specialized services with those providing other services/supports within the home and community care system and across each service area so as to build upon the opportunities and outcomes that require fulsome integration and connectivity of services to realize.

- Of note, when reviewing the list of community care services in *Regulation 386/99*, we were intrigued to see

  > 6. Independence training. - "independence training" means teaching the skills to improve independent functioning in the community, including the effective use of personal support services;

  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.

The ministry is 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, resident safety and security checks, and social and recreation services within a residential congregate care setting. This service could be combined with other home and community care services to support residential congregate care models (see "location of services").

- OSOT can support this recommendation.

Location of Services

The ministry is proposing to maintain the existing settings outlined in the *Home Care and Community Services, 1994* and *Ontario Regulation 386/99.* This includes a person's home, other community settings (e.g. adult day programs), congregate care settings (i.e. community clinics), schools, and long-term care homes in the circumstances outlined in that regulation.

- OSOT can support this position but raises an issue that has been troublesome since school health support services were largely transferred to the Ministry of Children, Community and Social Services.

  School-Based therapy services provided through Home Care are limited to private schools and children who are homeschooled. This separation of publicly funded schools from the private system has resulted in challenges in provision of services. Parents have expectations that children will receive the same services they would receive in the public system if not more because they are paying privately. However, LHIN contracts with private schools have been restrictive in the number of visits a child can receive. The situation is further complicated as the LHIN contract is with the school, not the service provider. Communication has been poor in many reported cases, resulting in new restrictions not being communicated, therapists extending visits that were then not approved for funding, etc. It has not been clear why this specific segment of schools were separated but, if schools remain a location for home care services, attention to how these services are engaged in private schools and home school environments needs to be addressed.

Restrictions based on setting would also be maintained, such as the prohibition against providing personal support services through home care in long-term care homes since these services are part of long-term care home services.

- While OSOT understands and supports the need to avoid duplication of service access, it is unclear whether if a resident of a long-term care home required aphasia services or pain management services as provided under community care services whether these would be accessible in the long-term care home.
- This would be a limitation if in future integration models, services such as seating and mobility assessment were to be more centralized to an OHT.

The ministry is proposing to add "public hospitals" as an eligible care setting for complex clients where the home and community care services pre-dated the hospitalization and are not expected to be needed post-hospitalization. These services would not be related to the reason for the person being hospitalized and where the hospital and the home and community care service provider have formally addressed issues of oversight and accountability.

- It is unclear how continuation of home and community care services that pre-dated a hospitalization would be implemented. Issues relating to hospital policies that restrict external contractors providing service are flagged as a concern. These have been issues for private OTs who have been contracted to provide services in a hospital. We query

whether union issues will interfere.

- While we raise concerns about issues that would need to be addressed to, in the spirit of enabling better integration, service efficiency and patient experience, if this recommendation contributes significantly to system efficiency it is important to explore.

The ministry is also proposing to add "residential congregate care settings" as a location in which home and community care services can be delivered. Proposed changes to the *Connecting Care Act, 2019* would provide a legal framework for the funding and oversight of non-licensed residential congregate care models. These models would introduce new settings of care in the community for patients who do not require the intensity of resources provided in a hospital or long-term care home, but whose needs are too high to be cared for at home. These models may provide care to patients on a transitional or rehabilitative basis, or over longer periods of time. Details of each residential congregate care model would be defined in regulation under the Act. The ministry would engage with the public, clients and caregivers and health system partners to develop each model and outline them in regulation.

- OSOT can support this recommendation and recognizes that increased flexibility in congregate settings where seniors or those with chronic disease/disability may dwell is likely a reality of the future.

- In light of the suggestion that new congregate care settings might serve as transitional or rehabilitative in focus, OSOT would value the opportunity to participate in further regulation development.

Method of Delivery

The ministry is proposing to continue the current methods of delivering care outlined in Ontario *Regulation 386/99*. This is consistent with a regulatory amendment that came into force on January 1, 2020 to clarify that services may be delivered virtually using electronic means. 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.

Maintaining this requirement will enable patients and providers to use technology to access health services in the most efficient way possible. Virtual visits and technology can be used to supplement in-person care but does not fully replace it.

- OSOT supports continuity of flexibility to provide services in-person, virtually, or in some hybrid of both if deemed appropriate based on the assessed needs of a client as assessed by the regulated provider that is to deliver the services *and* in keeping with the preferences of the patient.

- We note the reference to "visits" but make the assumption that the reference to "technology" extends the notion of virtual care to mean digital monitoring and other technology approaches that may not be provider engagements.

- Occupational therapists have had opportunity and indeed, challenge, to move quickly to engage virtual components of care during the current pandemic. Their experiences would support the statement that "virtual visits and technology can be used to supplement in-person care but does not fully replace it". Members also attest that delivery of care virtually does have additional costs attached, at least until public acceptance is such that suitable platforms are accessible to all, orientation and training is not required, etc. OSOT asserts that while care may be more cost-effective (e.g. travel costs can be averted), the value of the intervention remains the same (if not, it should be delivered in person) and should be compensated as such.

Eligibility for Services

The ministry is proposing to maintain the eligibility criteria for services as outlined in Ontario *Regulation 386/99*, including School Health Professional Services. This would include any update to eligibility made as the result of the public posting in 2019 related to providing access to home care services for people from another province or territory who were insured under a public health insurance plan and who require end-of-life care.

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. While this is appropriate in many cases, there are some circumstances in which this can be a barrier to effective care, such as if a client is ambulatory, but the closest setting to receive services is four hours away.

- OSOT supports the recommendation to maintain current eligibility criteria, although we have previously identified a caveat relating to school-based OT services. We have understood that school-based OT services funded through Home and Community Care were only eligible to students of private schools or those who are home-schooled. Our reading of the *Regulation 386/99* does not reflect this.

- Family physicians have, for some time, articulated concern and frustration that they are not able to access OT services for their patients through home and community care. There does not appear to be a restriction in the current Regulation, however, this may have resulted from cutbacks to services at the level of the LHINs. Enabling integration of home and community care services through integrated service organizations such as Ontario Health Teams, should, in our opinion, enabling primary care physicians to refer clients for home care services that promote/maintain independence and safety of their patients to live at home.

- OSOT supports the proposed flexibility of eligibility criteria for pharmacy and physiotherapy services. Presuming criteria for access to home-based Pharmacy and PT may be developed, it is important that policy implementation be equitable across the province.

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. This is a continuation of the current home and community care delivery model where approved agencies under the *Home Care and Community Services Act, 1994* are Health Service Providers funded by LHINs. These approved agencies must also be not-for-profit.

Like the model currently, the ministry is proposing that these not-for-profit organizations will be able to deliver services directly or indirectly through contracts with for-profit and not-for-profit providers.

It is anticipated that Ontario Health would fund home care services through an integrated model of care delivered by a Health Service Provider or Ontario Health Team. Reflecting current practice, these organizations would then generally contract for the delivery of those services. A direct funding relationship between a home care service provider organization and Ontario Health is not anticipated.

The ministry is proposing to maintain the current practice of delivering community support services, as defined in the *Home Care and Community Services Act, 1994* and *Ontario Regulation 386/99*, through not-for-profit providers. The ministry would outline this requirement in regulation, which would also apply to contracted community support services. Any existing contracts with for-profit organizations would be grand-parented.

This approach is intended to promote continuity of care and service provision, to promote the delivery of services in a more integrated way, and to continue to support the contribution of community volunteers and charitable donations in the provision of community care services.

- The Society recognizes the value in maintaining continuity of care and service provision and appreciates that the grand-parenting of existing contracts can lend stability of continuity in a transforming system.

- Over the many years that a competitive contractual model for home care services has existed, the Society has observed a number of flaws that we believe have impacted the quality of patient care:
    - Bid development (when RFPs occurred) were administratively burdensome and expensive, taking costs that could be directed to the frontline to contract management
    - The perception of costs sunk in administration for the LHIN contracting a service provider who then contracted multiple frontline providers is frustrating to frontline clinicians who see their compensation levels fall considerably below colleagues working in the hospital sector
    - Contracted professionals have had no job security, volume of referral protection and no paid vacation, sick time or benefits which impacts recruitment and retention of experienced clinicians to the sector

  COVID-19 has underlined this issue as many home and community care OTs saw significant reductions in referral volumes with no accommodating compensation.

As OHTs engage a "one organization" approach, the discrepancies in compensation levels amongst providers across different components of the OHT will become more visible.

Should this contracted model continue, OSOT urges a human resources retention review to consider steps that can be taken to ensure that frontline providers see their work valued equitably to colleagues in other sectors. Current practice tends to "ghetto-ize" the very sector we see to be so important to effective integrated system flow.

- It is unclear how conflicts of interest will be managed if home care service provider organizations are partners in Ontario Health Teams. On what basis are terms of contracts negotiated and managed if a service provider agency is a partner?
- Contracting of home care professional services has in the past resulted in a variety of service provider agencies providing contracted services for some but not all professional services. (e.g. a company may provide occupational therapy and physiotherapy services but not nursing or SLP). The resulting impact is that there is a disconnected team of providers serving a client needs. While this need not be a negative impact when processes exist to incent and fund team communication and interaction, the reality in today's home and community care system is that this very function of communication, team conferencing/planning is not funded as part of a visit model. Occupational therapists who wish to connect with multiple team players to coordinate care, communicate progress, etc. are obliged to fit this into their own time. If contracting of services to multiple providers is an ongoing commitment, OSOT asserts that funding policies and models support effective interdisciplinary teamwork when more than one service is required.

Charges for Services

Proposed changes to the *Connecting Care Act, 2019* would maintain the current prohibition on charging for home and community care services, unless permitted in regulation.

The ministry is proposing to maintain the current practice of allowing charges for the proposed list of community care services (community support services as defined in the *Home Care and Community Services Act, 1994* and *Ontario Regulation 386/99)*. Professional, personal support and homemaking services (when provided alongside personal support services) and security checks and reassurance services (when provided alongside other home care services) would continue to be publicly funded for eligible patients and no charges would be permitted by regulation.

This would maintain Ontario's publicly funded home and community care program, while recognizing that community services are provided through a combination of government funding, volunteer services, charitable donations and client co-payments

- OSOT is supportive of this recommendation, however, it is assumed that the 4 proposed new community care services would not be provided with a charge because they are not listed in the current regulation.

- While it is reasonable to set limits on what the publicly funded system is able to fund, an approach that requires client co-payments does create the situation where some people will be able to take advantage of community supports where others with less financial means may not. Consideration and support to review of social security supports is important to ensure that those community support services that will keep an individual in good health, out of hospital, and managing at home can be accessible to all, if only through access to social funding supports.

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) to ensure the performance of care coordination functions outlined below.

These Health Services Providers 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, through mutual agreement, to partner organizations with the goal of improving system navigation, reducing transitions for clients and eliminating duplication in assessment and care planning.

Care coordination functions would continue to include:

- **Assess a patient's need for home and community care services.**
- **Determine if the patient is eligible for home and community care services, in accordance with the patient assessment and the criteria outlined in regulation.**
- **Develop one home and community care plan for the patient based on the assessment. The care plan would be developed in partnership with the patient and/or the patient's caregiver and would align with their preferences and care goals. Care plans must be documented and shared with patients and/or the patient's caregiver.**
- **The care plan should identify outcomes, rather than simply hour or visit-based planning**
- **Manage the provision of services in a reasonable timeframe. If services are not available, the patient must be placed on a wait list.**
- **Coordinate services in care plan and work with parties in the circle of care.**
- **Support the patient to navigate needed health services within the care model.**
- **Manage issues with service delivery.**
- **Reassess and update care plans as required.**

Detailed expectations regarding care coordination would be outlined in policy. This could include:

- **Use of evidence-based assessment tools.**
- **Reassessment requirements.**
- **Guidance on care planning to ensure equity of access across the province.**
- **The organization of navigation, information and referral services among multiple organizations. The ministry would emphasize the need for integrated models of care coordination that reduce duplication in planning, such as the current requirement for a plan of service by an approved agency, and a plan of care by the service provider who delivers the care.**

- **Requirement for home care assessments to be performed by a regulated health professional.**

- Enabling Ontario Health Teams to place care coordination where it makes most sense is supportive to integrated care planning and oversight. OSOT can support this recommendation. It would be hoped that the expertise that exists in care coordination in the existing system model is not lost in any re-shuffling of location of service.

- Much of the role detailed for a Care Coordinator speaks to the development and oversight of a "care' plan; it is unclear whether this is inclusive of any treatment or intervention plan that a regulated health professional may develop with the client. OSOT applauds the move to a more needs-based, outcome focused approach to the delivery of services, however, in such a model the needs for a professional service would now, we expect, be driven by the RHP's assessment and input from the client and not by an algorithm or formula for a visit maximum. How is the treatment planning of multiple professional's integrated into the care plan?

- We believe the policy development for this role of Care Coordinator will be critical as this is a critical and central role in an integrated care model.

- Once again, we point out the frequent reference to "care" - in the title of the coordinator, in the care plan, etc. While within professional communities these terms are understood, the public message may imply that home and community services care is about being taken care of.

Service Maximums

Although *Ontario Regulation 386/99* under the *Home Care and Community Services Act, 1994* prescribes the maximum of services that can be provided, except in extraordinary circumstances, the ministry is proposing not to include service maximums in regulation under the *Connecting Care Act, 2019.* The ministry could provide guidance on care planning and service allocation in policy to promote equity of access across the province.

- OSOT emphatically supports a move to a needs-based, individualized approach to care.

- 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. 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.

Bill of Rights

The ministry is proposing to include a Bill of Rights for home and community care patients in regulation, similar to that outlined in the *Home Care and Community Services Act, 1994*. As is the case currently, patients who believe their rights have been violated would be able to make a complaint to their provider (providers funded by Ontario Health as well as contracted providers).

The Bill of Rights contained in the *Home Care and Community Services Act, 1994* would serve as the model for the Bill of Rights proposed for regulation. As the Bill was developed in 1994, the ministry is seeking feedback on updates that may be required related to the equitable inclusion of all Ontarians in the delivery of home and community care services.

- OSOT supports inclusion of a patients' Bill of Rights.

- It is noted that the existing Bill of Rights in *Home and Community Care Act, 1994* is quite lengthy. We have noted that it is sometimes edited when shared. For example, Community Legal Education Ontario references the Bill of Rights in the following way:

  The home care Bill of Rights says you have the right to:

  1. be treated with respect and to be free from abuse
  2. have your privacy and dignity honoured
  3. have your needs and preferences respected
  4. receive information about the services you get
  5. take part in decisions about your services
  6. consent to or refuse services
  7. comment or criticize without anyone taking action against you
  8. receive information about home care laws and policies and how to make a complaint
  9. have your home care records kept confidential

  We note with some concern that key elements of #3 are not reflected in this version as they are reflected in the Act as highlighted below

  3. *A person receiving a community service has the right to be dealt with by the service provider in a manner that recognizes the person's individuality and that is sensitive to and responds to the person's needs and preferences,* ***including preferences based on ethnic, spiritual, linguistic, familial and cultural factors.***

  We feel these commitments are particularly important to be visible and entrenched in the home and community care system at this time.

- We muse as to whether consideration has explored the notion of a patient code of conduct or expectations. In light of the serious allegations of workers in the home and community care system of verbal and sometimes physical abuse by clients, it may be appropriate to have a document identifying expected behaviours of clients, breach of which may impact access to services. This could be a part of an orientation package, and could also serve to place home and community care services in the context the

ministry would wish to see them, for example, what is the purpose of services offered – enablement versus care, etc.

Complaints

Proposed changes to the *Connecting Care Act, 2019* would require home and community care Health Service Providers to establish a process for reviewing complaints made by patients with respect to home and community care services in accordance with requirements set out in regulation.

The ministry is proposing to maintain the list of complaint topics outlined in the *Home Care and Community Services Act, 1994* in regulation, with some additions:

- **Decisions around eligibility.**
- **Exclusion of services.**
- **Decisions related to the amount of service.**
- **Decisions related to termination of service.**
- **Quality of service.**
- **Alleged violation of a person's rights (see "bill of rights" section).**
- **Violation of rights under other legislation related to their care, including consent, privacy and confidentiality.**

The ministry also proposes to maintain requirements for the handling of complaints, including:

- **The right of clients to be informed of the process to make a complaint, the right to make a complaint, and the right to be free from interference, coercion, discrimination or reprisal related to making the complaint.**
- **The current review period for responding to a complaint; and**
- **Who must be given notice of a decision made about a complaint.**

Maintaining these requirements in regulation would ensure patients continue to have the opportunity to voice their concerns around the provision of home and community care services and keep organizations accountable for providing quality home and community care services that meet the patients' needs.

- OSOT supports ongoing processes for clients and their families/caregivers to voice concerns about the care and treatment they receive. Complaint processes must be transparent, easily accessible, part of an orientation package, and equitably adhered to.

Appeals

Proposed changes to the Connecting Care Act, 2019 would maintain a person's right to appeal to the Health Services Appeals and Review Board (HSARB), and provides regulation making authority to outline the parameters of eligible appeals.

The ministry is proposing to maintain existing parameters in regulation. The regulations would prescribe the same types of decisions that can be appealed to the HSARB under the Home Care and Community Services Act, 1994:

- **Decisions about ineligibility to receive service,**
- **Decisions to exclude a service,**
- **Decisions related to the amount of service, and**
- **Decisions to terminate service.**

Requirements to provide notice of an appeal to the HSARB, the details of the hearing including the when a hearing should take place, providing notice of the hearing, and outlining the parties to an appeal would also be maintained.

- In that the regulations can set out the parameters of eligible appeals, OSOT queries why patients and their families/caregivers could not appeal any decision relating to a complaint. Proposed appeals exclude appeal of decisions relating to quality of service, violation of rights under other legislation relating to their care, and alleged violation of a person's rights as identified in the bill of rights. The rationale for these exclusions is not clear.

Self-Directed Care

Proposed changes to the *Connecting Care Act, 2019* would enable Ontario Health to fund Health Service Providers and Ontario Health Teams to provide funding to patients to purchase and manage their own care. Currently, only LHINs are able to fund patients directly.

The ministry is proposing to maintain the current parameters for self-directed care captured under the *Home Care and Community Services Act, 1994*, *Ontario Regulation 386/99* and the Family-Managed Home Care program specifications in regulation and policy.

The following would be included in regulation:

- **Requirements outlined in Section 28.5 (4) of the *Home Care and Community Services Act, 1994.* This includes:**
    - **The requirement for patients to have a care plan to be eligible for self-directed care.**
    - **The discretion of the home and community care Health Service Provider (including LHINs) or Ontario Health Team to determine eligibility for self-directed care. Ministry of Health Proposed new regulation under the *Connecting Care Act, 2019* (Pending passage of the *Connecting People to Home and Community Care Act, 2020*)**
    - **The application of the complaints and appeals framework to decisions made regarding amount of service.**
    - **The non-application of other sections of the proposed home and community care regulation, specifically, the right to appeal decisions regarding eligibility for self-directed care to HSARB.**
    - **The ability of a Health Service Provider or Ontario Health Team to set terms and conditions of self-directed care funding.**
- **The continued grand-parenting of existing self-directed care programs.**

Eligible client cohorts covered by the program would be done through policy. The ministry is not seeking feedback on home and community care policies at this time.

- OSOT does not identify any objection to these recommendations but queries the rationale for excluding the right to appeal a decision regarding eligibility for self-

directed care to HSDARB.

LHINs as Health Service Providers

Proposed amendments to the *Connecting Care Act, 2019* would enable LHINs to be deemed Health Service Providers under that *Act* on an interim basis. The ministry is proposing regulations to give this effect.

This would be required when the *Home Care and Community Services Act, 1994* is repealed and the LHINs are funded by the ministry. 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. This is critical to ensuring that home and community care patients receive equitable care, regardless of who provides it.

- OSOT supports this recommendation

Ontario Regulation 179/95

The ministry is not proposing to maintain the provisions outlined in *Ontario Regulation 179/95* under the *Home Care and Community Services Act, 1994* related to the conveyance of assets.

- No comment

Ontario's home and community care services are critical to the successful transformation to a truly integrated health care system. Occupational therapists recognize the value and import of community-based services and extend commitment to work within the profession and in support of regulation and policy development to advance the provision of community-based services that support Ontarians to experience health, well-being and quality of life in their own homes.

Please do not hesitate to contact the Society if further clarification of any of our points is required or to seek additional inputs.

Sincerely,

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