February 10, 2022

Mr. Joshua Lovell
Manager, Implementation (Acting)
Funding, Finance and Seniors Program Unit
Home and Community Care Branch, Ontario Health Teams
Ministry of Health

Via Email

Re: Home and Community Care Transformation Consultation Provider Partnerships

---

Dear Mr. Lovell,

The Ontario Physiotherapy Association (OPA) with over 6,000 member physiotherapists, physiotherapy residents, physiotherapist assistants, and students is the Ontario Branch of the Canadian Physiotherapy Association. Our members provide physiotherapy services in all sectors of the health care delivery system, including home and community care.

We are pleased to have this opportunity to provide feedback to this consultation on the 'Improve Accountability in Delivery' area for transformation in the home and community care (HCC) sector of the health system. The stated goals of this key area include increasing stability and continuity of HCC service delivery during the transformation, which requires a focus on health human resource capacity and workforce stability, including considerations about capacity-building. In pursuing these goals, we note that this is also an opportunity to address many of the inequities in funding and compensation that were cemented into the contracts in this sector at the time of divestment in the late 1990's. We also note that best practices in treatment and service delivery models have evolved and the complexity of care provided in the community has increased. These changes must also be considered in improving accountability in delivery in the home and community care sector.

416 322 6866 1 800 672 9668 opa.on.ca
110 SHEPPARD AVE EAST, SUITE 810, TORONTO ON M2N 6Y8

Elements of the quadruple aim, integral to health system transformation, are included in the commitments to be achieved in addressing needed changes to the contracted model. We have, therefore, framed our feedback on the framework of quadruple aims and strongly believe that changes in the key area of 'Improve Accountability in Delivery' should be used to incentivize achievement of these aims.

Aim: Improving Patient and Caregiver Experience

- **Funding levels must be sufficient to achieve the desired outcomes for patients and caregivers.** Currently, there is insufficient funds in most cases to provide rehabilitation in home care as recommended by best practices for specific conditions, to achieve the desired client outcomes. These limits on resources mean that often the number of visits are restricted and what can be achieved, at best, is a safe transition to home with limited rehabilitation provided in-home. As client outcomes are included in the aim to improve accountability, there needs to be an appropriate level of resources to achieve those outcomes through best practice, whether the funding model is a per visit fee or a bundled program fee.

- **Ontarians should receive the same standard of care coordination and determination of care plans regardless of region or which type of health service provider coordinates care.** Currently, there are significant variances in the application of care coordination and planning. These variances will likely grow with the entry of other agencies and Health Service Providers becoming providers of home care.

- **Patients and Caregivers should receive a seamless integrated care experience.** With services through Home and Community Care Services (HCCS) and through other agencies, such as hospitals and family health teams, we are already seeing increased fragmentation of services even within the same episode of care. In some cases, policies for eligibility may act as a barrier as both streams cannot be accessed at the same time.

- **Transparency of accountability structures are critical to individuals and communities served by HCC programs.** Clients need to know how to address concerns with service delivery organizations and who they are accountable to. In the prior single entry system where all home care services were accessed via HCCS (CCACs then LHINs), clients had more clarity on how to address their questions or concerns. HCCS and new models of care should not contribute to fragmentation or complexity in system navigation for patients or caregivers. Contracts should include commitments to contribute to a seamless, integrated delivery of care and transparency in accountability to the public.

Aim: Improving the Health of Populations

- **Where there is established regional health services, such as Six Nations Health Services (SNHS), there is an opportunity to repair the fragmentation of services between federally funded programs and provincially funded programs for Indigenous communities.** For example, a senior in the Six Nations community would have accessed all home care services previously through SNHS but after a total hip replacement, they return to the community, must be discharged from SNHS services and access care through the HCCS and external SPO. This is fragmentation. One organization, in this example Six Nations Health Services, could provide all services for both funding sources. This would minimize fragmentation and allow for continuity of care and better health outcomes.

- **Patients and communities should have equitable access to the same levels of care regardless of when they need services throughout the year.** Contracts must take into account the variances of demand and need, allowing for flexibility to meet unexpected demands and need over the full fiscal year. As with any volume-based funding model, there have been challenges in consistently allocating visits across the whole year. Even when resources are split across the whole year, it is difficult to predict surges in demand over time. SPOs/HCSAs may manage this funding model by either conserving visits early in the fiscal year or rationing in the last financial quarter to ensure they have resources over the year or are able to respond to an unpredicted surge. This impacts the equity of care clients receive, and ultimately their outcomes, depending on time of year they access care.

- **Patients and communities should have equitable access to home care services and regional differences should be taken into account in funding and service level contracts.** There are significant differences between regions on availability of rehabilitation services (e.g., access to outpatient rehabilitation or specialized in-patient programs) and geographic access to services and access to transportation (e.g., rural vs urban). Funding must not solely be based on the total of population served but must be reflective of the regional resources available and the added challenges to provide equitable access to care in rural and remote settings.

Aim: Reducing per Capita Cost of Health Care

- **Procurement processes, contracts, and accountability structures must not add undue complexity or increase the administrative burden within the system.** Each layer of administration or management adds cost to the system and reduces available resources for the provision of services. Sharing of administrative resources and best practices are often limited in competitive bidding environment. Standardization of some elements and incentives to collaborate can help to reduce duplication and decrease costs.

- **An investment in rehabilitation reduces the per capita cost of health care.** Provider contracts and performance measurement should allow for innovative programs that meet regionalized health needs with a focus on rehabilitation in order to reduce dependence on care services, allow aging at home safely, and reduce re-admissions to hospital and emergency room demands.[1] Access to rehabilitation reduces care needs and results in significant savings to the per capita cost of health care. The Rehab Care Alliance, in their white paper on Community-Based Rehabilitation noted that in-home rehabilitation programs for frail seniors increased their strength and function, diminishing their requirements for personal support workers and associated costs.[2] They also provide an example of the South West Ontario Community Stroke Rehabilitation Teams, who provide in-home rehabilitation for those who cannot access specialized out-patient services. The program resulted in a net monetary benefit of $43,655 over usual care.[3]

Aim: Improving the Work Life of Providers

- **Correct the historical inequities in fees and compensation existing between rehabilitation professionals.** The original divestment of the vast majority of in-house professionals to a procurement model with competitive bidding in the late 1990's cemented assumptions on fees and how services are delivered that continue to impact health professionals and working conditions.

  Assumptions included the length and frequency of visits by different professional disciplines. With the in-house model, physiotherapy visits were approximately 30 minutes each and more frequent, and occupational therapy visits were between 45 minutes to an hour and less frequent. During the divestment, fees were determined based on the in-house model, however, best practices and complexity of care have changed how services are delivered. Different regions were frozen at different times in their processes for contract renegotiations when all came to a halt. There are some contracts outstanding that would be unnaturally low for physiotherapy due to that timing.

  Additionally, in the physiotherapy funding reform (2013), new fees, related to congregate settings, were applied only to physiotherapists and have not been applied to date for other rehabilitation professions acting in congregate settings.

---

[1]http://www.rehabcarealliance.ca/uploads/File/Initiatives_and_Toolkits/Ontario_Health_Teams/Rehabilitative_Care_-_Essential_Component_of_Connected_Care.pdf, accessed February 7, 2022, p2.
[2] http://www.rehabcarealliance.ca/uploads/File/Initiatives_and_Toolkits/Community_Rehab/RCA_Community-based_Rehab_White_Paper_Part_2.pdf, accessed February 8, 2022, p. 13.
[3] Ibid, p. 22.

ONTARIO PHYSIOTHERAPY ASSOCIATION

As a result, despite the increasing complexity of care and the fact that, for the most part, visits by rehabilitation professionals are the same length of time, physiotherapists are paid 30% to 45% less on average than their comparable peers in other rehabilitation professions. Provider partnerships and agreements must achieve equitable compensation within home care between comparable professions and across sectors within the health system. Equitable compensation between professionals within an SPO and between SPOs, and between the home care sector and other sectors of the health care system is required to achieve this aim.

- Accountability structures must include requirements for equity and fairness in workplace conditions, including safety. There are substantial variations in work conditions depending on the region or the health service provider that hires the professional.

- Agreements should ensure that any integration of rehabilitation assistants, including physiotherapist assistants, be based on best-practices, appropriate to the level of services needed, and contribute to the increased capacity to expand access and meet health outcomes.

- All health professionals should be enabled to work up to their full scope of practice to optimize the capacity of the sector, and their clinical knowledge and judgement be supported to provide care in a manner to achieve health outcomes for individuals within a best practice framework. Contracts and accountability structures should recognize and enable this.

- Contracts should ensure that all professional time must be compensated for and valued including care planning, charting and record keeping, and coordination and engagement of health professionals in program development and implementation of best practices.

- Expanding outcome measures beyond process indicators to health outcomes must be appropriately resourced and valued. Increasing reporting requirements can place a greater burden on front line providers to do reporting and submission of client data, which often adds to the 'impossible days' faced by front line providers. Technology and electronic health records has not reached its full capacity to support some of this. The current funding model does not take into account charting and reporting demands.

- Accountability structures should include an ombudsman option for health care workers in home and community care. At this time, there is little to no mechanism except for the market to hold health service providers accountable for how those who provide direct patient care are treated. In no other sector of health care is the distance between the source of funding (government) and the health care worker as great as it is with home care, which has within it multiple layers of health care

organizations and health service providers. This has led to substantial variations in work conditions depending on the region or the health service provider that hires the professional. The pandemic has pulled back the curtain on health human resource concerns for health care professionals in this sector, including issues of safety, equity in compensation, and working 'impossible days.' Recruitment and retention in the home care sector has been a growing issue for many professions, including physiotherapy, for years.

We thank you for this opportunity to provide feedback and look forward to future dialogue and engagement in this process.

Sincerely,

Dorianne Sauvé
Chief Executive Officer