MAKING WAY FOR CHANGE:
TRANSFORMING HOME AND COMMUNITY CARE FOR ONTARIANS

A white paper from the Ontario Association of Community Care Access Centres

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About this white paper:
Like many jurisdictions around the globe, Ontario is grappling with the need to transform its health care system to meet the needs of its changing populations today, tomorrow and over time. The Ontario Association of Community Care Access Centres (OACCAC) developed this white paper to give decision makers expert and insider knowledge about the complexities of today's home and community care system and how they can be streamlined and strengthened to improve quality, access and value at the patient and system levels. Informed by the rich experience of CCACs who've cared for millions of Ontarians as well as by the sector's data and system-wide analysis of trends and outcomes in care delivery, *Making Way for Change: Transforming home and community care* for Ontarians offers recommendations to help bring out the best in home and community care for patients, caregivers and the system.

MAKING WAY FOR CHANGE: TRANSFORMING HOME AND COMMUNITY CARE FOR ONTARIANS

Health care in Ontario is changing. Efforts are underway to create a whole and holistic system to help patients and caregivers to experience as few gaps, gridlock, detours or dead ends as possible. But health care cannot be transformed into a true system without reforming home and community care to draw fully on the unique strengths and services it offers patients, caregivers, health partners and the health system as a whole. To make home and community care more robust and responsive to patient needs, we need a series of significant and interconnected changes that break down barriers and build on its ability to increase access, quality and value for money.

The government has already started to shift its focus and some funding, from acute to home and community care, rightly delegating it new responsibilities. Community Care Access Centres (CCACs) have adapted and delivered results despite labouring under outdated structures, funding models and legislation. To meet the diverse needs of an aging population and growing numbers of patients with chronic and increasingly complex conditions, the sector needs updated structures, processes and funding frameworks. With those in place, the home and community care sector, led by CCACs, will be better positioned to improve patient experience and outcomes and help transform and sustain the system.

What should publicly funded home and community care look like in that future? What should it offer the thousands of patients and caregivers who every year rely on it to help them and their loved ones stay well – and stay at home? The Ontario Association of Community Care Access Centres (OACCAC), whose members served 700,000 patients in 2013/2014 alone, has a vision of, and for, the future of home and community care. It is a visibly patient-centred system that is:

- Responsive to and respectful of patients' needs
- Integrated with other health and social service providers, efficiently maximizing limited resources
- Consistently available through a single point of access and equitable across the province
- Accountable, transparent and intact for future generations

The OACCAC also offers a clear picture and evidence of what the sector does well, what it needs to improve, and what limits its progress. What are the unique strengths and areas of expertise that the home and community care sector offers to advance individual and system-wide goals? What barriers are holding it back?

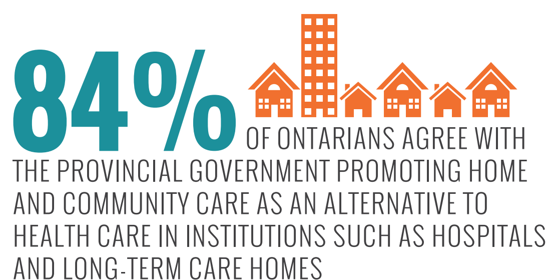
Every day, in every corner of the province, patients are cared for in their homes by dedicated nurses, personal support workers, rehabilitation professionals and many other health providers. Since CCACs were created, the home and community care system in Ontario has become a key pillar of health care that hundreds of thousands of patients and their families rely upon every year for safe, effective and dependable care and support in their homes and communities. It has also become complex.

A patchwork of processes, policies and programs that currently exist have been layered on, adjusted and readjusted over the years, while approaches to procuring services have also shifted. Legislation and regulations governing home and community care, along with the structures and practices put in place for a different time, population and system, are overdue for an overhaul. Long-term planning and system design have failed to keep pace with increased patient volume and complexity. All these factors have inhibited innovation and the consistent province-wide spread of improved models of care.

Even with these challenges, the home and community care sector has helped solve or reduce critical system-wide problems. Hospital and long-term care home capacity issues, for instance, benefit from CCACs managing in-home care for more and more people with complex health needs who would have previously been placed, sometimes unnecessarily, in institutional care at a much greater cost to the system. Home and community care offers, or can offer, the whole system many other advantages; it is time to further develop and use them. Consider what CCACs offer:

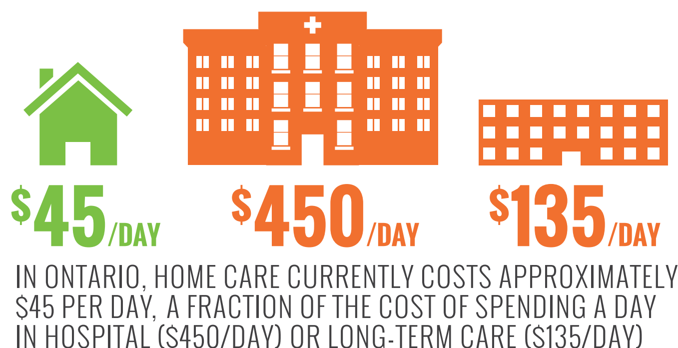
- A single point of access and accountability for home care and long-term care placement in every community across Ontario
- An effective regional system of professional care coordination linking home care with hospitals, primary care and other health and social service providers
- Standardized, evidence-based assessment tools that inform individual patient care plans and system-level planning and performance measurement
- One electronic health record for every home care patient – the first and only one in Ontario
- A single information technology network that enables patient information to be shared securely among care providers. The electronic health record, which includes assessment and service information for millions of patients, provides a rich source of information to inform health system planning and evidence-based care planning guidelines and service models
- A growing capacity to identify, collect, analyze and validate unique and valuable data to drive evidence-based decision making about the types and quantities of services that enhance health outcomes

The public sees the value and importance of a strong, stable, integrated home and community care system. Eighty-four per cent of Ontarians agree with the provincial government promoting home and community care as an alternative to health care in institutions such as hospitals and long-term care homes.[1] Hospitals, home and community care and long-term care rely upon each other to transition patients to the best place for their care. The public's preference for home and community care is also good news for the province's financial health. In Ontario, home care currently costs approximately $45 per day[2], a fraction of the cost of spending a day in hospital ($450 per day)[3] or long-term care ($135 per day).[4]



[1]Ontario Home Care Association, May 23, 2014: http://www.homecareontario.ca/public/about/home-care/system/facts-and-figures.cfm#edn14 .
[2]OACCAC Utilization Reports, Average Monthly Utilization for Long-Stay Patients, MAPLe High and MAPLe Very High, FY 2013/14; % spending on purchased services, medical equipment & supplies, Care Coordination, A&O FY2013/14.
[3]OHA, OFCMHAP, OACCAC, "Ideas and Opportunities for Bending the Health Care Cost Curve" (April 2010); confirmed with OHA on June 23, 2014.
[4]Includes supplemental and Level of Care funding. Does not include the client copay contribution.

Patients, caregivers, hospitals, primary care physicians and other health professionals depend on the province to ensure the structure and system-wide supports are in place to continue to improve and enhance the home and community care system in Ontario. Since November 2007, CCACs have contributed to a 16 per cent reduction in the overall number of patients waiting for alternate levels of care in hospital,[5] allowing more patients to wait in the comfort of their own homes. CCACs recognize that change is needed soon, and are ready and eager to drive innovative improvements to make home and community care in Ontario the best it can be.



We know government resources are limited. As stewards of those resources, it is our responsibility to use them as efficiently and effectively as possible in the interest of patients, caregivers and the public.

THE FACTS ABOUT THE CURRENT SYSTEM

As a key part of the home and community care system, CCACs have a mandate to coordinate care, help residents access long-term care homes and other settings, and provide information and referral services. CCACs provide in-home care for people of all ages and in-school care for children, in every community across Ontario. CCAC services are fully funded by the Ontario government and include nursing, rehabilitation therapies and personal support services, as well as medical supplies and equipment needed to support care. Many patients receiving care from CCACs also receive services from other community organizations such as adult day programs, meals on wheels, and transportation.

Professional CCAC care coordinators use standardized, evidence-based tools when conducting comprehensive assessments, connecting patients and caregivers to appropriate services and supports and informing them of all available resources. The services available in the publicly funded home and community care system may not fully address all patient expectations; care coordinators are most often the ones to explain to patients, families and caregivers the limits of government-funded services.

CCACs receive referrals from hospitals, family physicians, community agencies, family members, friends and individuals who refer themselves. Last year, CCACs delivered care to 700,000 people in homes and communities across Ontario. This includes:

- Providing 575,000 patients with care at home
- Ensuring 89,000 children receive health services at school
- Supporting 27,000 people through their end-of-life experience with care at home
- Managing 26,000 placements to long-term care
- Making thousands of referrals each day to other community support services, among other care responsibilities[6]

[5]Ontario Hospital Association, "Alternative Level of Care (ALC)", May 2013.
[6]Table 3: Individuals Served by Organization, CCAC MIS Comparative Reports 2013/2014YE (MOH Health Data Branch Web Portal).

CCACs have been working together and in partnership with acute care, primary care and other community providers to coordinate a comprehensive range of services to ensure that patients can live at home. The evolution and success of Community Health Links echo the CCACs' pursuit of coordinated care: CCACs are key partners in shaping and developing the 47 Health Links operating in Ontario. CCACs:

- Work directly with nearly 10,000 primary care providers, a number that continues to grow
- Work in approximately 75 per cent of Ontario's 184 Family Health Teams
- Work in every hospital across the province to bring approximately 200,000 people home from hospital with CCAC care each year

CCACs provide care coordination and other services through health care professionals that they employ directly. The vast majority of home care and school health services are provided by agencies with whom CCACs contract to deliver nursing, therapies, personal support and other services. There are more than 260 separate contracts.

CCACs are committed to ensuring taxpayer dollars are spent effectively on patient care. They have reduced the proportion of funding spent on administration and overhead from 9.3 per cent in 2008/09 to eight per cent today.[7] While this number is already lower than those of other health service providers, administrative infrastructure is a necessary component of a complex contract management system to measure performance and quality, manage billings, and ensure accountability for public expenditures. It should be noted that each contracted provider also has its own administrative infrastructure. Further reductions in administration are possible, but limited by the current model for service delivery.

THE CASE FOR CHANGE

Demographic trends tell a clear story: over the next 25 years, our population will age and become even more diverse. How and where people live, and what their needs and expectations are, will change; their health care must also change. Home and community care is set to take on an even more prominent role in the health care system over the next two decades, as more people with more complex needs than ever before require access to care. People with multiple, complex health conditions who would have lived in an institution five years ago are now living successfully in the community. Demand for safe, high-quality home and community care will keep growing: more people will need care more quickly to lead independent, empowered lives.

CCACs are caring for more and more people with multiple chronic and complex health issues. In 2013/2014, 64 per cent of CCAC patients with continuous care had high-care needs.[8] No longer just an option for some, home and community care has become part of the foundation of our health care system.

However, a recent paper by the Canadian Medical Association and Ipsos Reid indicates that over three-quarters of older Canadians are concerned about having access to high-quality home and long-term care in their retirement years.[9]

[7] Table 1A. Client Services, Admin & Support, Overhead and Other Expenses, CCAC 2013/14Q3 Global Reports Total Revenue and Expenses, OHRS Report, Ministry of Health and Long-Term Care Health Data Branch Web Portal.
[8] OACCAC utilization report: Average Monthly Active Complex and Chronic referral.
[9] "National Report on Home Care: Seniors Health Issues and the Impact of an Aging Population", Canadian Medical Association and Ispos Reid Public Affairs, August 2014.

The health care workforce is also aging. The average age of family physicians in Canada is just over 50 years and the average age of registered nurses is just over 45 years.[10] Only one-quarter of Ontario's personal support workers, who provide the lion's share of in-home care for seniors, are under 40 years of age.[11]

Shifting care from hospitals to the home and community also creates greater expectations for family members and other informal caregivers to absorb a higher burden of care and cost. The home and community care system cannot function without the critical contribution of informal caregivers. In the years to come there will be a growing need for that informal support, with fewer and fewer informal caregivers to provide it. At a recent citizens panel co-sponsored by the McMaster Health Forum and the OACCAC, participants reflected on the importance of supporting informal/family caregivers to deal with the emotional, physical and economic burden of caregiving at home.

Technology innovations are also driving and enabling change. The evolution of technology and e-health will help shape and potentially make quality health care more affordable. People of all ages are increasingly comfortable with technology in their daily lives. The convergence of medical and information technology with consumer technology will continue, putting life-changing technologies in the hands of patients and providers alike. Mobile technology, system information sharing, and data-driven improvements are essential to quality and value in home and community care.

BARRIERS LIMITING TRANSFORMATION

Complex service delivery model

As originally conceived in the 1990s, CCACs were designed to be:

- A fully competitive model based on quality and price
- A neutral broker commissioning services and providing case management separated from direct home care service delivery
- Fully divested of all direct care providers
- Focused on quality oversight and resource management for services delivered by service providers, while community support service agencies were to focus on volunteer-delivered services

This model has never been fully realized nor comprehensively reconsidered in 20 years. An external review of competition and contracting processes conducted in 2004 offered recommendations to improve the process,[12] but ultimately a full competition-based model was deemed unworkable. Many perceived contract transitions as too disruptive for patients and destabilizing for home care workers. The province continued the moratorium on competition, and in 2012, the policy on home care service provider procurement was formally changed and replaced by long-term performance-based contracts, with competition by exception only.

[10]Canadian Institute for Health Information, Regulated Nurses, 2013.
[11]"Ontario Personal Support Workers in Home and Community Care: CRNCC/PSNO Survey Results.
[12]"Realizing the Potential of Home Care: Competing for Excellence by Rewarding Results", Elinor Caplan (2004).

This evolution has led to overly complex business arrangements involving CCACs, contracted provider agencies, regions and services, together amounting to:

- More than 1,500 service arrangements
- More than 14,000 different billing rates
- Hundreds of millions of transactions annually (e.g. orders, confirmations, billings, payments), not including medical supplies and equipment

A single provider agency might have many contracts with a CCAC, each contract with different billing rates for personal support services, nursing visits and nursing shifts, as well as many different rates for clinics or specialized services, such as pediatric care, complex wound care or end-of-life care.

The ability to monitor, control and ensure quality of care at the patient level is embedded in the terms and contracts of many service providers. CCACs must negotiate with individual service provider organizations within the contract framework to integrate necessary innovations and address service quality issues. There have been a number of challenges with the current service delivery model, including the lack of full transparency inherent in a contracting model and the difficulty of driving consistent reform across a complex system. Some of those challenges were evident during the recent implementation of the Personal Support Worker Stabilization Strategy.

Structure of the home and community care system

The consolidation of 42 CCACs in 2008 to 14 agencies aligned with Local Health Integration Network (LHIN) borders created a region-wide platform for providing access and coordinating care. The value of this consolidated structure as a change agent was evident during the recent implementation of changes to the delivery of community physiotherapy services. In less than six months, the CCAC sector successfully transitioned more than 30,000 patients from OHIP-funded services to CCAC physiotherapy services, while developing and testing new evidence-based in-home care models to meet their needs.

CCACs have made many changes since consolidation. They have built partnerships, created economies of scale, streamlined access and improved consistency of care. However, the broader home and community care system is made up of thousands of agencies with varying structures and mandates, and multiple administrative and governance structures. That makes building and maintaining relationships time consuming and difficult, especially without a strong collective voice and common, consistent approach. This can make it confusing and challenging for patients to access the right care, receive consistent quality of care, and benefit from new and innovative services at the same time as other patients. It can also result in differing service availability for patients across CCAC boundaries. Furthermore, the legislation guiding public sector labour transitions makes even small-scale health services integration long-term projects.

The challenge of achieving an integrated, streamlined continuum of care in Ontario is complicated by the wide range of health service providers involved in the delivery of home and community care – from hospitals to long-term care homes to the thousands of small community service agencies. Ontario is moving closer to system integration and CCACs have a long history of wrapping services around the needs of patients in collaboration with other health providers; *home first* and CCACs' across-the-board participation in provincial Health Links are just two recent examples. Governance remains an underlying issue, which other provinces have addressed by adopting single governing authorities for regional health care.

Lack of funding stability and predictability

Funding stability and predictability have significant impacts on the consistency of care and the quality of a patient's experience within the home and community care system. Patients in the Greater Toronto Area who cross LHIN boundaries, for example, experience the impact of these funding variations. How and when home and community care funding is allocated in Ontario makes it more difficult to deliver consistent levels of care and positive patient experiences.

Too often, it is more than half way through the fiscal year before CCACs' annual funding allocations are confirmed. By then, the expanding demands, patient volumes and increasing complexity of patients' health care needs leave CCACs little flexibility in their budgets which must by law be balanced. Most CCAC patients have long-term needs that require multi-year commitments, making budgeting more difficult. In any given month, the objective for the majority (over 52 per cent) of the population CCACs serve is to restore or maintain the functions that allow them to live in the community successfully.

In recent years, additional funds have become available in the last quarters of the year for CCACs to use before fiscal year-end. Often these funds are targeted, one-time-only, with no increase to base and no continuation of funding. CCACs must quickly ramp up services, identify new patients or new service levels for existing patients, provide additional services for a few months, and then ramp down to previous levels before year-end. Patients should not be managed into and out of the system like this. Under these conditions, strategic or innovative use of these funds to implement real change in the delivery of services is unlikely.

This approach creates an annual cycle of service fluctuations that undermines patients' confidence in the home and community care system, creates significant human resource challenges for contracted service providers, and frustrates hospitals and other health system partners who rely on home care services to help manage appropriate placement of patients. Inequity in funding levels, compounded when enhancements are evenly spread across regions, make equitable access to consistent levels of care difficult to achieve. Last year, for instance, the province committed to increase funding for home and community care by four per cent; the portion provided to CCACs varied from 27 per cent of the total community investment to 69 per cent. These allocations were not necessarily driven by need or equity considerations; rather they were assessed at each LHIN's discretion and based on local system pressures and varying priorities.

THE NUMBER OF INDIVIDUALS SERVED BY CCACS HAS INCREASED 101 PER CENT SINCE 2003/2004

While the government has consistently supported home and community care, the total share of investment in home care as a percentage of overall health care expenditure has increased marginally – less than one-quarter of a percentage point in the past 10 years. Over the same 10 years, patient volumes and acuity have increased dramatically. The number of individuals served by CCACs has increased 101 per cent since 2003/2004,[13] and the number of long-stay, high-needs patients has increased 73 per cent since 2009/2010.[14]

THE NUMBER OF LONG-STAY, HIGH-NEEDS PATIENTS HAS INCREASED 73 PER CENT SINCE 2009/2010

[13]Table 3: Individuals Served by Organization, CCAC MIS Comparative Reports 2013/2014YE (MOH Health Data Branch Web Portal).
[14]OACCAC utilization report: Average Monthly Active Complex and Chronic referral per cent change from FY2009/2010 to 2013/2014.

LHINs were created to plan, fund, and integrate services at the regional level while ensuring accountability for those funds. The Ministry of Health and Long-Term Care was to become a steward, setting health system strategies and goals and providing a legislative, regulatory and policy framework to support the devolved responsibility for health system management. This vision has yet to be fully realized. The Ministry continues to directly fund and manage key services and programs and requires separate and different accountability structures for them. Consider the following:

- Funding policies and models do not yet fully promote evidence-based allocation and value for money
- Hospitals, primary care, home and community care, community support services and long-term care are treated as discrete slices of the funding pie rather than as a continuum where funding truly follows the patient
- The complexity of the community system provides opportunities for highly variable investment decisions across LHINs
- Late funding decisions and lack of predictability year-over-year lead to service fluctuations that are challenging for patients, home care service providers and health system partners
- Local and system-wide capacity planning is not available to support funding decisions and provide a consistent, rational framework for service and human resource planning

Better alignment of roles, responsibilities and authorities would yield better outcomes for all.

An outdated legislative, regulatory and policy framework

To find the right balance between equitable and consistent access to care and local responsiveness to unique community needs, a clear, modernized legislative, regulatory and policy framework for the home and community care system is required. CCACs operate in a tightly regulated system compared to other community health and support services providers, and to those of other provinces and territories. Ontario's home care services are fully funded; patients do not pay directly for services. The regulatory framework has developed over time as a mechanism for controlling costs through access and service levels. It has been repeatedly adjusted to respond to population changes and system pressures, yet there has been no comprehensive reconsideration of the underlying framework.

The restrictions in the regulatory framework inhibit the ability of the province, the LHINs, and the home and community care sector to drive innovation to enhance patient care. This need not be the case. Saskatchewan, Manitoba, Quebec, New Brunswick and Nova Scotia designed more flexible and creative care plans for individual patients, setting home and community care maximums based on the equivalent cost of an institutional bed, without setting limits for individual services. Certain populations with long-term health needs would also benefit from new models, including direct funding models, which give them greater control over their services.

Many changes over the years have added to the complexity of the service delivery system. Regulatory amendments that came into effect on July 1, 2014, under the *Home Care and Community Services Act, 1994*, are a case in point. Those amendments enable both CCACs and community support service providers to deliver personal support services, creating the potential for parallel delivery systems for the same service. Improving access to services is essential, but the structure for service funding and accountability must be clear to prevent further confusion and parallel processes for patients needing those services.

The OACCAC is interested in solutions. In that spirit, we recommend the following reforms to the out-of-date legislative and regulatory framework governing home and community care:

- Define the continuum of care
- Enable and support flexible, responsive service delivery models
- Reduce duplication and administration in delivering services (e.g. personal support services, electronic health information sharing)
- Support consistent service levels through flexible service maximums that allow services to be tailored to meet a patient's unique needs
- Promote integration through labour laws that balance worker protection and the imperative of health system change
- Ensure that quality improvement and patient engagement are core principles

Integration is a strong lever of health system transformation. The *Local Health System Integration Act, 2006* (LHSIA) requires LHINs and health service providers, such as CCACs, to identify opportunities to integrate services to improve the delivery of appropriate, coordinated and cost-effective services. One of the challenges of integration is finding the right balance between driving innovation and health system improvement while protecting the rights of valued workers who provide care as change occurs. It is time to identify and discuss changes to the *Public Sector Labour Relations Transitions Act* (PSLRTA) that will address its disincentives for health system integration.

Health sector legislation has not yet fully evolved to support technology innovations designed to improve patient care and patient safety. The OACCAC has developed a unique single provincial electronic health record for all home care patients. CCACs have also developed the technology to enable rapid, secure health information-sharing between providers and other health system partners. Yet, there are no legislative and policy provisions to guide electronic health information sharing and address related privacy and security matters. That means health service providers devote time, money and effort developing one-off data and network sharing agreements that may not reflect leading practices.

Significant savings and efficiencies could be achieved, along with assurance of patient privacy and information security, if legislative provisions or policy guidance with respect to data and network sharing were developed. That essential work should anticipate how it can support the review and safe adoption of new and emerging technologies that improve patient care while improving system efficiency and capacity.

ENABLING TRANSFORMATION, IMPROVING CARE

Transformation demands a plan for the whole system that recognizes the interconnectedness of the sectors and the impact of their reforms on patients, each other, and system performance. That plan and its successful implementation depends on leadership, commitment, collaboration and steady pursuit from and among government, care providers and health system partners, including CCACs.

The CCACs are on board. They have streamlined administration, embraced and executed new direct care program responsibilities, delivered on priorities such as reducing wait times, and, working within limitations, continue to find new and better ways to improve access, quality and value. True transformation is hard, and must proceed with transparency, clarity, accountability – and with as little disruption to patients as possible. Hesitancy will only make the job harder. Without change, progress stalls, fragmentation and expensive inefficiencies persist and the system fails the patients and caregivers it is mandated to serve.

The OACCAC is making four key recommendations to improve patient care and provide increased quality and value for money.

RECOMMENDATIONS TO MAKE WAY FOR CHANGE

1. A FLEXIBLE, ADAPTABLE HOME CARE SERVICE MODEL

The complexity of the current home care service delivery model contributes to variability across the province in how care is delivered, in the cost to administer care and in the quality of care received. Patients are often unclear about whom to contact when they experience problems – their home care worker, the service provider agency, the CCAC care coordinator, and/or their family physician or primary care provider. A successful, timely resolution to a patient's concern depends on many accountabilities and communications channels, and a shared commitment to openness and transparency.

Ontario needs a home care service delivery model to:

- Drive the provision of high-quality home care that is more responsive to patients' needs and choices
- Provide patients with streamlined access and coordinated care
- Ensure optimal value, accountability and transparency
- Enable the rapid, system-wide adoption of innovations and evidence-based practices

What Ontario needs:

- Service planning policies based on individual and patient population needs and choices, including options that support people to direct their own care
- More flexibility in the way services are delivered based on demonstrated quality in providing better service to patients and better value for public investments
- A simplified service purchasing model achieved by developing a provincial rate for purchased home care services that is sensitive to local conditions, such as variable travel cost
- A rationalized continuum of home and community care that reduces duplication, streamlines access, and ensures coordinated care for patients

2. FUNDING STABILITY

The stability and predictability of funding over time are key to driving sustainable innovation and continuity in patient care. It is not capital or bed capacity that holds us back. Funding is the primary driver of capacity, followed closely by the availability of human resources.

What Ontario needs:

- An exploration of options to improve continuity of care to patients through earlier funding allocations and predictable funding levels year-over-year
- The implementation of the Health-Based Allocation Methodology aims to address inequity over time. But, adjustments in the short-term to address inequities in the funding base are necessary now.
- A provincial funding framework to determine home and community care funding at the regional level to ensure more equitable, evidence-based and performance-driven funding decisions

3. LONG-TERM CAPACITY PLANNING, INCLUDING HUMAN RESOURCE PLANNING

Many stakeholders have identified the need for forward-looking regional health system capacity planning to ensure that future investments are aligned with evolving population needs, support health system transformation and provide optimal value for taxpayers. Health human resource planning is a critical component of capacity planning to ensure that a well-trained workforce will continue to be available with the right skills to deliver high-quality care to Ontarians wherever they live. The OACCAC recommends province-wide planning within a consistent framework to ensure equitable access to comparable services to meet patients' current and future needs. The framework should be guided by evidence and require broad public and stakeholder engagement.

What Ontario needs:

- Provincial tools and guidance to drive long-term, evidence-based regional health planning that:
    - Provides a consistent basis for funding and service development based on strategic health system priorities
    - Aligns with the broad health system transformation agenda
    - Includes health human resource capacity planning to ensure workforce stability, value-for-money and continuity of care

4. LEGISLATIVE RENEWAL

These recommendations – and the reform they would enable – require new legislation. The current statute guiding the delivery of home and community care was designed in a different time to support a different system, and a different population with different needs. Much has changed in the 20 years since the *Home Care and Community Services Act* was passed. New services and structures have evolved and the strategic objectives of the health care system have been redefined, in part to reflect the changing needs of Ontario's population.

The home and community care system is currently guided by a complex, unaligned patchwork of legislation, regulation and provincial policies that has not undergone a comprehensive review in two decades of significant health care and other public policy shifts. A modernized statute and accompanying regulatory and policy changes would help embed a renewed home and community care sector as a key pillar of the health care system, with appropriate authority and accountability for achieving sector goals in support of health system transformation objectives.

To address real inhibitors to providing more integrated care within a seamless cross-continuum of health services, we need to examine changes to labour legislation that balance the rights of workers and bargaining agents with health system transformation imperatives to improve patient care and experiences.

Much depends in health care transformation on putting the legislative structure in place to ensure that new technology can be integrated appropriately and safely into care delivery, without creating significant administrative burdens for care providers.

Finally, the *Excellent Care for All Act* (ECFAA) is landmark legislation establishing Ontario's commitment to the provision of high-quality health care. CCACs have been preparing for the expansion of ECFAA to the broader health care system and encourage the Ministry to bring CCACs fully under the scope of the Act.

What Ontario needs:

- A modernized *Home Care and Community Services Act* that reflects the principles of health system transformation, establishes flexible, adaptive service policies, and defines a continuum of home and community care that is aligned with health system strategic objectives
- A streamlined framework for labour transitions to enable system transformation
- A framework to facilitate electronic health information sharing and reduce current administrative burden (data/network sharing agreements)
- Expansion of the ECFAA to CCACs and other health service providers

MAKING WAY FOR CHANGE

These reforms will create the foundation for a truly patient-centred home and community care sector that is fully integrated with other health care providers, consistently available across the province, responsive to and respectful of patients' needs, innovative and, technology-based, as well as accountable, transparent and scalable for generations to come.

Patients and their families can expect:

- Better access through fewer doors
- More consistent levels of service and access across Ontario
- Care innovations supported by evidence
- Reinvestments in care from efficiencies gained through transformation
- A health care system that operates to serve them seamlessly, safely, efficiently and effectively – offering the best care for Ontarians

These reforms must start as soon as possible; there is serious work to do and results take time. As these reforms move ahead, CCACs are committed to working closely with the Ministry and health system partners to continue innovating to improve access, quality and value for patients and to drive greater transparency and accountability. This includes:

- More robust patient, caregiver and partner engagement to ensure the care, services and support we provide is responsive, inclusive and timely
- Leveraging our provincial data stores to drive continuous quality improvement, value for money and evidence-based care
- Strengthening our partnerships with primary care, hospitals, long-term care homes and other community providers to integrate care delivery through initiatives like Health Links
- Continuing to move forward in implementing a transparency roadmap designed to enhance accountability

CCACs are eager to start the dialogue for change and the hard work, in respectful collaboration with the Ministry, health system partners, providers and, of course, patients and caregivers. We know we have more work to do to ensure seamless boundaries and smooth transitions for all patients, regardless of where they receive care in the province. Let's begin, together.

Ontario Association of Community Care Access Centres (OACCAC)

The OACCAC works with its members to advocate for sector/system reform to improve access, value and quality for patients and the system. Together, and with health partners, we develop innovative and cost-effective ways to provide Ontarians with the home and community care they need to stay well, and at home.

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