VON Pre-budget Submission

A submission by VON Canada

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Context

There is a compelling need to immediately scale up home and community care capacity and innovative models to address overcrowded emergency departments, lengthy wait times for long-term care and high rates of alternate level of care (ALC) beds within Ontario hospitals.

Over the past year, the Ontario government has demonstrated a clear commitment to home care modernization: legislation has been introduced to enable significant structural reforms and Budget 2022 allocated an additional $1 billion over three years. This is on top of the $500+ million previously announced in 2021 to address hospital ALC beds and the transition to a more efficient and effective system. These funding commitments represent a positive step toward transforming our sector, and we look forward to their ongoing allocation.

The attached submission includes three overarching recommendations that will allow more frail Ontarians access to appropriate services to comfortably "age in place" at home. We also highlight several home and community care programs and services offered by VON Canada or our partner organizations that meet the needs of clients and families and help keep them out of hospital or long-term care — and do so cost-effectively. Expanding such programs will help to stabilize and build capacity within the existing home and community care system while progressively shifting to a better overall model for health care in the future.

BRING HEALTH HOME

VON, along with three other leading home care organizations in the province, put forward recommendations to government for directing the funding to have the most impact and value. This submission builds on the recommendations of that report,

***Bring Health Home* (October 2022).**

Recommendations

1. Using a portion of the $1.5 billion allocated to home care in 2021 and 2022, immediately increase funding to:
    a. **Expand existing home care models**, including "hospital to home" strategies, that are cost effective, optimize client needs and preferences and enable alternate level of care (ALC) patients to safely transition home.
    b. **Enhance relevant community support services**, including home supports, meals and transportation programs, that divert frail elderly from emergency departments, hospital admission and long-term care.
    c. **Increase contract rates** to help stabilize the home care workforce.
2. **Create funding flexibility** that increases client access to care, reduces red tape and enhances innovative new models and patient and family choice.
3. Continue to increase investment in home and community care towards a **target of 10% of total health spending**, based on the demonstrated value for money.

It's what Ontarians want — and reflects government and health system priorities

VON's recommendations align with the priorities and direction already set by the Ontario government, and if acted upon, will assist the government in more expediently creating the desired future state of our health system. Two of Ontario Health's strategic priorities for 2022/23 are reducing health inequities and maximizing system value by applying evidence.[1]

According to the guidance provided to Ontario Health Teams by Ontario Health, Ontarians expect a healthcare system that:

- takes care of a person's complete physical and mental health needs, and not just one condition at a time;
- provides the appropriate level of care in the appropriate setting, at the right time; and
- achieves better value by delivering better quality for the same or lower cost.[2]

Further, these recommendations also reflect what a vast majority of Ontarians want: 93% of seniors would prefer to stay at home with their family with additional supports rather than move into a long-term care facility.[3]

The time to act is now

Underlying these recommendations is a call for urgent action. Without it, the system cannot respond to the current and escalating healthcare capacity demands. Healthcare leaders have long been raising concerns about Ontario's aging population: Ontario's Ministry of Finance projects rapid growth in the proportion and total number of seniors between 2021 and 2031 as the last cohorts of Baby Boomers turn 65. Over the longer term, the number of seniors will increase significantly, from 2.7 million, or 18.1% of the population, in 2021, to 4.4 million, or 21.8%, by 2046.[4] We must also plan now for the additional pressures that will be placed on acute care due to a projected 37.7% population increase over the next 25 years.[5]

Ontario households in which at least one resident received home care in the last year were asked if home care services helped the recipient stay at home. 84.6% of respondents said it was "very helpful."

2021 Canadian Community Health Survey, Statistics Canada

We cannot afford the time or money required to build and operate the volume of hospitals or long-term care beds needed to meet projected needs based on Ontario's current population models. We must invest in the most cost-effective and patient-centred approaches to care that can help immediately relieve pressure on the costliest types of care in our overburdened system.

VON is the largest provider of both home care and community support services in Ontario. For decades we have offered proven approaches and models that meet the needs of the most vulnerable members of our communities while offering significant value for money. Investing in home and community care is a sound — and timely — investment that has tremendous

[1] Ontario Health. Annual Business Plan 2022/23.
[2] Ontario Health. *Ontario Health Teams: Guidance for Health Care Providers and Organizations*.
[3] Home Care Ontario. *Staying Home & Staying Healthy: Home Care in the Time of COVID and Beyond*. October 2020.
[4] Government of Ontario. Ontario Population Projections Update, 2021-2046.
[5] Government of Ontario. Ontario Population Projections Update, 2021-2046.

potential to alleviate burdens on hospitals and other institutional care — a key priority in an effective and efficient healthcare system.

Recommendation 1a. Expand existing home care models, including "hospital to home" strategies, that are cost effective, optimize client needs and preferences, and enable alternate level of care (ALC) patients to safely transition home.

Inappropriate placement of patients leads to system bottlenecks, such as excessive numbers of ALC beds, increased wait times for long-term-care beds and an increase in emergency department visits. Ensuring Ontarians have timely access to the level of post-discharge care they require will help facilitate timely discharge from acute care to home.

This can be challenging however, in the face of a province-wide nursing shortage. Community nursing clinics and eHomecare are two models used at VON that allow fewer nurses to provide more care more efficiently.

Community nursing clinics in a "clinic first" approach

In a "clinic first" approach, home care clients who are physically able to leave their home are treated by either a registered nurse or registered practical nurse at a community nursing clinic rather than in their homes. In-clinic treatment allows patients to book appointments for a time most convenient for them. The clinics themselves can be flexible to best meet the needs of the clients in the community. Hours of operation can be adjusted to align with high-use times. Same-day referral hours and ensuring ease of access to public transit can further support access for marginalized clients.

Nursing clinics increase the efficiency of nursing hours, a health human resource that will likely remain in short supply well into the future. Without the need to drive between clients' homes, a nurse can see more than twice as many clients in-clinic in the time that it takes for a single home visit[6]. VON is currently expanding its successful home care clinic models, specifically in regions where nursing shortages are the most acute.

VON nursing clinics work closely with local hospitals and other primary and community care providers and can have a direct impact on ED volumes and hospital

Hospice@Home - Aamjiwnaang

Client profile: Indigenous people who want to spend their end-of-life journey in the community where they have lived their entire lives yet have limited access to culturally relevant and formalized palliative care programs.

How it works: VON worked in partnership with Aamjiwnaang community members to co-design a model of in-home palliative care based on VON's successful Hospice@Home program. VON provided the clinical training required for personal support workers from the Aamjiwnaang community to become healthcare technicians and deliver care that reflects the Indigenous history, culture and traditions of the community.

System impact: The collaboration between VON and Aamjiwnaang community members in the co-design and delivery of culturally relevant end-of-life care in their own homes increased access to end-of-life care in Indigenous communities. It is also an example of the kind of solution we need to utilize to address health equity issues and improved person-centred care across the province.

Value for money: Each patient is cared for in their home by a healthcare technician (HCT) who is remotely supervised by a directing registered nurse (DRN). A single DRN, located anywhere in the province, can supervise five to six HCTs at one time, using well-established technology called eShift.

[6] VON Nova Scotia, personal communication

lengths-of-stay. Post-hospitalization provision of vital care, which may delay discharge, can be booked at a nursing clinic prior to the patient leaving the hospital. Clinics can incorporate high-demand specialty nursing care, such as wound care. Wound management is one of the most common (estimated to be up to 50%), and costly interventions for individuals receiving home care services.[7] In addition, infusion therapy, catheter care and injections are examples of post-discharge care commonly provided at such clinics.

eHomecare

eHomecare is an approach to care for specific clinical populations that supports earlier discharge from hospital and ED diversion. The model is a hybrid between in-home care and virtual care, offering the best of both approaches.

One registered nurse can remotely supervise multiple healthcare technicians (personal support workers with additional training). The model facilitates integration between providers as all members of the care team, including the primary care provider, can remotely access the client's information.

This model has proven successful in promoting earlier discharge from hospital for patients with chronic disease[8] and is also being used with complex pediatric clients and to expand access to at-home hospice palliative care (see Hospice@Home).

[7] MacIsaac, C. Closing the Gap Between Evidence and Action: How Outcome Measurement Informs the Implementation of Evidence-based Wound Care Practice in Home Care. *WOUNDS* 2007; 19(11):299–309

[8] Beal, J., McKelvie, R., Gibson, J. et al. Connecting Care to Home for Heart Failure Patients: An Effective Strategy to Reduce Hospital Readmission Rates. Canadian Journal of Cardiology 2019; 35 (10): S201-202.

Recommendation 1b. Enhance relevant community support services, including home supports, meals and transportation programs, that divert frail elderly from emergency departments, hospital admission and long-term care.

Between 30-55% of poor health outcomes[9] are due to non-medical factors such as low income,[10] poor nutrition,[11] [12] [13] lack of social support,[14] lack of access to primary care,[15] [16] [17] and lack of transportation.[18]

It is therefore not surprising that Ontarians from the lowest income demographic are more likely to visit the emergency room within seven days of discharge from hospital (7.25% versus 5.72%) and within 30 days of discharge (11.83% versus 5.40%). They were also more likely to be readmitted within 7 days (2.54% versus 2.13%) and 30 days (5.83% versus 4.50%).[19] In Toronto, those in the lowest income category were 2.3 times more likely to be admitted to hospital or undergo day surgery when compared to those in the highest income level (360 per 100,000 versus 158 per 100,000).[20]

SMILE (Seniors Managing Independent Living Easily)

Client profile: Clients of SMILE (Seniors Managing Independent Living Easily) have trouble with tasks of everyday living and are at risk of hospital or long-term care admission. SMILE can be implemented in any community, for any population, but it is particularly helpful for clients experiencing financial, geographic or cultural barriers to support.

How it works: SMILE offers navigation and delivery of community-based supports to keep clients living in their own homes longer. Low-income clients also receive an annual budget to pay for eligible services and supports. Currently, the program in southeastern Ontario serves more than 2,000 clients, three-quarters of whom receive an annual stipend.

Value for money: SMILE staff provide an overarching layer of navigation and coordination to the delivery of services and supports that already exist in the community. More than 70% of the per-day, per-client costs to deliver the program go toward client service budgets.

System impact: SMILE can keep seniors living at home longer, can facilitate earlier discharge from hospital and provide the range of support required by clients waiting in hospital for a long-term care bed.

A 2022 survey of 354 SMILE clients showed that 85% had not visited the emergency department in the past six months and 65% had not been admitted to the hospital in the previous six months.

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[9] World Health Organization. Social Determinants of Health.

[10] Canadian Institute for Health Information. 30-day Overall Readmission, 2020

[11] Lærum-Onsager, E., Molin, M., Olsen, CF et al. Effect of Nutritional and Physical Exercise Intervention on Hospital Readmission for Patients aged 65 or Older: A Systematic Review and Meta-analysis of Randomized Controlled Trials. *International Journal of Behavioral Nutrition and Physical Activity 2021; 18*: 62.

[12] Curtis, LJ, Bernier, P.,Jeejeebhoy K. et al. Costs of Hospital Malnutrition. *Clinical Nutrition 2017; 36*(5): 1391-1396.

[13] Fingar, KR, Weiss, AJ, Barrett, ML et al. All-cause Readmissions Following Hospital Stays for Patients with Malnutrition. *Statistical Brief #218.* Agency for Healthcare Research and Quality, 2013.

[14] Hu, J., Gonsah, MD & Nerenz, DR. Socioeconomic Status and Readmissions: Evidence from an Urban Teaching Hospital. *Health Affairs 2014; 33*(5).

[15] Lam, K., Abrams, HM, Matelski, J. et al. Factors Associated with Attendance at Primary Care Appointments after Discharge from Hospital: A Retrospective Cohort Study. *CMAJ Open 2018; 6*(4): E587-93.

[16] Dupre, ME, Xu, H., Ganger, BB et al. Access to Routine Care and Risks for 30-day Readmission in Patients with Cardiovascular Disease. *American Heart Journal 2018; 196*: 9-17.

[17] Gregor, J., Payrard, L. & Donzé, J. Associations Between Post-Discharge Medical Consultations and 30-day Unplanned Hospital Readmission: A Prospective Observational Cohort Study. *European Journal of Internal Medicine 2022; 99*: 57-62.

[18] Gregor, J., Payrard, L. & Donzé, J. Associations Between Post-Discharge Medical Consultations and 30-day Unplanned Hospital Readmission: A Prospective Observational Cohort Study. *European Journal of Internal Medicine 2022; 99*: 57-62.

[19] Ontario Health. Transitions Between Hospital and Home Quality Standard. November 2019.

[20] Canadian Institute for Health Information. Measuring Trends in Health Inequalities in Cities: Hospitalization and Day Surgery Indicator Results, Overall and by Census Metropolitan Area— Data Tables. Ottawa, ON: CIHI; 2019.

Economically disadvantaged and rural residents of this province are being disproportionately affected by the current state of its healthcare system. It makes sense (and is supported by evidence) that upstream care and services that address the social determinants of health and increase health equity for these groups (also referred to as "wrap-around care") can prevent the need for expensive downstream care.

Recommendation 1c. Increase contract rates to help stabilize the home care workforce.

For decades the home and community care sector has been mired in an outdated funding and regulatory model that prioritizes visit levels over patient outcomes, rigid adherence to process over innovation and cost control over public value. The sector has also been chronically underfunded: from 2016-2021, the provincial average increase in home and community care spending was 30%. In contrast, Ontario increased its spending by only 19%.[21]

An increase in contract rates is necessary to ensure that home and community care organizations can continue to provide cost-effective care and services and recruit the staff required to do so. Consideration must be given not only to wages but to benefits, travel costs, schedulers and technology. There is an increasing number of unfunded operational requirements, including updating technology systems and training requirements for increasingly complex clients, for which service provider organizations (SPOs) such as VON are not receiving additional funding.

Cost pressures can also vary between regions, leading to differing levels of access for Ontarians depending on where they live. For example, the cost of providing care in rural and remote areas is higher, but contract rates do not reflect these regional nuances. The Auditor General of Ontario highlighted inconsistency between rates of SPOs for the same services. In her 2015 report, the Auditor General pointed out that there were 14,000 different contract rates for 94 service categories.[22]

[21] Canadian Institute for Health Information. National Health Expenditure Trends, 2021: Data Tables, Series D4.

[22] Auditor General of Ontario. 3.01 CCACs—Community Care Access Centres—Home Care Program. *Annual Report 2015.*

Recommendation 2. Create funding flexibility that increases client access to care, reduces red tape and enhances innovative new models and patient and family choice.

Complex funding models, "red tape" and funding silos undermine the ability of all SPOs to maximize the use of existing funds and pursue innovative service delivery. As we look at health system reform, we need to maintain the client and family lens to ensure we build care pathways that are intuitive, integrated and enhance care experience and outcomes. Limits on compensation and the inability to move funds from one program to another to better meet the needs of clients can often result in longer waitlists, unmet care needs and inefficient use of existing resources. Bundled funding is an alternative funding model in which a single amount is used to fund all aspects of a client or patient's care pathway across multiple providers and settings, over a fixed period of time —promoting better integration across providers and care settings.[23]

LEGHO (Let's Go Home)

Client profile: LEGHO (Let's Go Home) is a bundled-care approach to community support services for seniors and adults with physical disabilities who have been discharged from hospital to home or who present at emergency departments with needs related to social determinants of health.

How it works: For four to six weeks after discharge or ER visit, the client receives a standard bundle of publicly funded community support services that includes meals, transportation, homemaking and more. A care planner works with the client as a single point of contact to set up and initiate multiple services and supports. The LEGHO program is delivered by a lead community and social service (CSS) agency with the LEGHO program lead accountable to the local Ontario Health Team.

System impact: Similar programs offered in the province at the local level serve clients who have many risk factors for costly hospital admission, or who may end up with an ALC designation or be a frequent user of the emergency department. Often, these individuals have an average age of 75, multiple chronic conditions, live alone and are low income.

Value for money: These programs cover the costs of CSS for up to six weeks for less than $1,000 per client. ALC beds in hospital cost approximately $750 per day.

Recommendation 3. Continue to increase investment in home and community care towards a target of 10% of total health spending, based on the demonstrated value for money.

Over the last ten years, the average percentage of total home and community healthcare spending in the province has remained consistent, averaging only 6.2%.[24] Many countries, like the Netherlands and Denmark, have developed innovative models and redirected higher percentages of total health spending to support frail elderly "aging in place".[25]

This approach has significantly enhanced capacity for older adults and those of all ages with frailty issues to more economically remain in their homes longer, living more vital, active and rewarding lives. It has also taken major pressures off other parts of the system including acute and long-term care.

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[23] Bundled payments (nd). Evidence and Perspectives on Funding Health Care in Canada. University of British Columbia Centre for Health Services and Policy Research.

[24] Canadian Institute for Health Information. National Health Expenditure Trends, 2021: Data Tables, Series D4.

[25] Palmer, KS, Stalteri, R & Zogo, CO et al. *Home Care for Older Adults During the COVID-19 Pandemic: Lessons from the Netherlands, Denmark, and Germany to Strengthen and Expand Home Care in Canada.* Issue Note on Home Care. CanCOVID. March 25, 2022.

Ensuring our sustainable future

Over the past year, the Ontario government has communicated a strong commitment to home care modernization that is long overdue. The previously announced home and community care investments must be quickly and strategically allocated within the sector to begin to meet current demand. Over the longer term, the government needs to ensure the sector is adequately funded and resourced. The included recommendations are designed to stabilize and build capacity in the existing home care system, while simultaneously and progressively shifting to a better overall model for the future: a sustainable, integrated health system that fully incorporates home and community care and ensures people receive care in the most appropriate, cost-effective setting at any given time.

Home and community care reform is a fundamental pillar of government's approach to fixing "hallway healthcare" and ensuring the sustainability of our system into the future. It is not surprising that most Ontarians want to remain at home in their own community as they age. Their home connects them to a community they helped build, and to their friends, neighbours and family members. It represents their accomplishments and their legacy and is part of their cultural, spiritual and personal identity. Most of all, it's where they feel safe. We must collectively work with government and system partners to give all Ontarians the opportunity to age in place.

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