“Uberizing” home care in Ontario

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Abstract
This article looks at home care in Ontario and its role as a foundation for a sustainable healthcare system in the future. Beginning with the history and evolution of the service delivery model, it examines current challenges and opportunities to unleash the potential of home care within a more integrated model for patient-centred care for the future. An in-depth look at how to better coordinate, integrate, and fund care for patients is highlighted.

Introduction
Home and community care is the foundation for a sustainable healthcare system for the future. A strong and stable home care system can contribute considerably and positively to improving patient care, reducing healthcare system costs, decreasing lengths of hospital stays, and shorter wait lists for long-term care.1,2 Unlocking the potential of Ontario’s home and community care means moving away from the current “one-size-fits-all” service delivery model to better meet the needs of different populations of clients. It also requires thoughtful approaches to examining and revising long-standing policies, regulations, and practices that have shaped the current approach to care. In essence, home and community care needs “uberizing”—introducing positive, disruptive change that drives more patient-centred, equitable, and responsive care delivery.

In December 2015, the Ontario Ministry of Health and Long-Term Care announced its Patients First action plan, which proposes substantial changes to how primary care, home and community care, and public health are organized and delivered. Under the plan, the role of the Local Health Integration Networks (LHNs) will expand to include direct responsibility for home care services currently delivered through Community Care Access Centres (CCACs) and greater accountability for other parts of the health system. This model will combine greater responsibility for health system planning and funding with delivery of care in a regional structure, but unlike regional health authorities in other provinces, the new LHIN/CCAC entities will only have direct delivery responsibility for home care. Changing the organizational structure and leadership with a reimagined LHIN/CCAC entity will not, in and of itself, address the fundamental challenges of Ontario’s home and community care sector; however, a new LHIN/CCAC entity could have fresh levers to strengthen and modernize the home and community care sector.

The history and evolution of CCACs
Publicly funded home care was established more than 50 years ago as a pilot program in Toronto, Ontario. Currently, there are 14 regional CCAC organizations in the province, which are responsible for the coordination and delivery of publicly funded home care. Like many other aspects of our healthcare system, the home care system we have was designed for a different era and patient demographic. Market pressures, including changing patient populations and expectations, are driving the critical need to mobilize the home and community care sector into a more patient-centred, technology-enabled, and streamlined system of care delivery that can support the complex health and social care needs of our current and future patients. All evidence points to “care closer to home” as an essential component for health system transformation in healthcare globally.

The current structure of Ontario’s home and community care sector is unnecessarily complicated. Complexity results not only from the number of organizations involved in the delivery of home care but also in the fact that they all have their own unique policies and processes that contribute to variations in patient care and experience.

There are 14 CCACs, 160 contracted service providers that work with CCACs, and close to 1,000 agencies that provide community support services such as meal programs and homemaking services. In the late 1990s, the provincial government made substantive changes that impacted home care, including having CCACs procure local services through a competitive bidding process that resulted in hundreds of contractual arrangements for care delivery. But in more recent years, other than changing geographic boundaries served by CCACs and virtually eliminating the competitive bidding process, the basic model of how the system is organized to deliver care has not been altered. In fact, CCACs are now tied to an infrastructure designed for a non-existent competitive procurement model, while no longer able to derive benefit from market competition.

In every sector of our economy, we see the impact of market forces, competition, and disruptive technology changing how businesses are operated, workforces are organized and trained, and the type of work that is required. Yet the current home care delivery model cannot, by its design, meet the needs of clients...
and caregivers without substantial workarounds. At the same time, Ontario’s home and community care system now supports among the most complex home care patients in the world. This shift is placing significant pressure on CCACs as resources are reallocated at an escalating rate to support more complex patients.

Despite facing the same market forces as other sectors, publicly funded healthcare delivery has stayed relatively unchanged. It remains provider driven and designed for a patient demographic that no longer exists. The transformation that needs to happen must be supported by a forward-looking policy framework that is keeping pace with the evolving needs and expectations of patients and caregivers for the healthcare system. With rising healthcare system costs and other economic challenges facing the province of Ontario, it is time to reassess current home care policy and establish the best model to support Ontario for the future.

**Why do we need to reconsider our service delivery model for home care?**

Evidence for the need to modernize the home and community care delivery system and its underlying policy framework is mounting. In 2015, the Home Care Expert Panel report, Ontario’s Home Care Roadmap, and the Minister’s Patients First proposal all pointed to key opportunities for improvement. The Auditor General’s report from a special audit on home care released in September 2015 indicated that “The solution is not simply to add initiatives and make adjustments to existing services, leaving core problems and inconsistencies entrenched. Instead, the Ministry, CCACs and their Association have an opportunity to bring fresh and innovative perspectives to identifying the outcomes they need to achieve, and to defining the kind of system that can produce those outcomes cost-effectively and consistently across the province.”

Contributing factors to the current state of home and community care include:

- a complex, fragmented delivery home care model and a complex fee schedule that accompanies this multitude of contracts;
- a non-functional procurement model that no longer provides the benefits of market competition, for example, allocating service volumes based on quality;
- a standardized one-size-fits-all contract for all home care providers that does not meet the needs of different home care populations and that poses barriers to adoption of innovative service delivery, enabling technologies and new funding models;
- a predominantly pay-for-visit model that incents delivery of higher volumes of service rather than improved quality, client outcomes, or cost-effective care delivery;
- additional costs related to the current model, such as duplicate assessments and inefficient distribution of services;
- contracts that are not aligned with geographic regions or population needs but are instead based on historical contracted market shares; and
- changes to contracts, including service volumes and advances in care delivery, which require both CCAC and service provider negotiations at a provincial level, as well as extensive labour negotiations between service providers and their collective bargaining agents at a local level.

**Designing a new home care model**

As noted above, numerous reports on home and community care published within the past few years have identified fragmentation as a major challenge to patients and their families navigating Ontario’s system. Patients have reported concerns about frequent and repetitive assessments, information gaps in their care, confusion about whom to contact for a given condition or treatment, frequent staff turnover, and staff scheduling changes. An improved patient experience requires a much higher degree of integrated care and reduced complexity in delivery.

Building on the principles for patient-centred care in Ontario’s Excellent Care for All Act (2010), home care needs to shift to a more streamlined patient-centred model, with a focus on one community-based team, one point of contact, one assessment, a shared health record, more flexible care options, and improved local integration and collaboration with primary care and other community supports. In addition, with an aging demographic, the system needs to find more cost-effective ways to deliver higher quality care, including increased use of enabling technologies, remote monitoring, better utilizing informal caregivers, and shifting care to less costly options including up-skilling the home care workforce. Right now we see new models being tested, including giving patients and families more control through access to funds they can use to select and manage their own care teams, training families to help care for patients with dementia or other advanced chronic illness, using cell phone cameras to track wound healing over time, joint visits between primary care physicians and home care workers, and having home care nurses follow their patients into hospitals. However, these small pockets of innovation are not creating change at the pace that is needed. The Minister’s Patients First action plan proposes creating more integrated models of care delivery in which home care staff would work in a team-based model with primary care, community support, hospitals, and public health. This requires re-envisioning how care is provided, changes the roles and responsibilities of team members, blurs the lines between healthcare organizations, and reorganizes healthcare planning and delivery. Modernizing the CCAC service delivery model will require asking and answering some hard questions.
On what assumptions should we base a new service delivery model?

Here are some considerations:

- Clients and caregivers should drive the delivery of care, including what, how, and when care is delivered. Clients should be engaged not only in their own care but more broadly in how healthcare is designed.
- Clients supported in the community have increasingly complex and chronic illnesses, and delivery of this care requires multiple providers, often working for different organizations. Care is safer and of higher quality when care is integrated across these multiple providers, and clients and caregivers experience their care as being delivered by a single team.
- Care options and levels of care should be transparent to clients and caregivers so that they can plan ahead and make informed choices as their care needs change over time.
- We can reduce duplication in the system and reduce the amount of time clients and caregivers spend sharing their health histories and improve efficiency of the care delivery process by optimizing team support processes such as shared assessments, shared care plans, electronic communications, and health records.
- Care options for both clients and caregivers should include the use of innovative and enabling technologies that enable 24/7 access to care and make better use of health human resources, such as via “Skype,” remote monitoring technology, and self-monitoring apps that enable patients and caregivers to be more engaged in managing their own care. The increased use of technology makes better use of a limited pool of specialty staff (advanced practice nurses, home care pharmacists) and reduces reliance on one-to-one, visit-based care as the only option.
- Care delivery can be more cost-effective if new service delivery models and funding approaches minimize inefficiencies and address volume-based pricing, price variation, and misaligned incentives for care delivery.
- There should be fewer provider contracts, with those providers offering a fuller range of services. We need to give opportunity for existing smaller, single service providers to partner with other organizations, integrate, or transition their operations. Providers need to align their teams to work as part of larger integrated teams that include the CCAC, primary care, community support services, and others.
- We need to shift from transactional relationships between CCACs and providers (referrals, visits) and align incentives for desired outcomes, increased expectations for outcomes, use of pathways and best practices, and integrated care.
- Community Care Access Centres need to have increased flexibility to determine and implement the best delivery models to improve client outcomes and value for money (eg, when to purchase services, when to partner, when to deliver services directly, when to support client-directed funding).

How can we create a sustainable health human resource strategy for home care?

Ultimately, the success of home care depends on those who deliver it. Home care is in urgent need of a targeted health human resource plan that ensures the strength of a community workforce that is fairly compensated, has stable income from week to week, is sufficiently skilled and trained for the jobs they are expected to do, and is provided with incentives for delivering higher quality care and better health outcomes. Home care needs access to the training, support, and infrastructure for quality improvement that are available in other parts of the health system. We also need to consider which employment models for home care staff, including contracted employment, full-time employment, salary-based, fee-for-service-based, casual or temporary staffing models, will best work to support different populations of patients and caregivers in a more integrated, team-based system of the future.

How do we move ahead?

As noted, the CCACs’ delivery system is extremely complex, with multiple contracts, multiple billing codes, and variable pricing. It is therefore an important goal for CCACs to streamline and modernize service offerings by creating and implementing a single, integrated team approach for more complex client populations across the province. It is expected that such a move will improve the quality of care and client experience, align service delivery models to client needs, and address issues related to continuity of care. Further to this, CCACs can also create a platform that supports frontline providers in working more effectively—particularly in interdisciplinary teams and one that minimizes disruptive change for both clients and frontline providers.

How can the CCACs properly provide services to meet the needs of their clients?

To do so, there needs to be increased flexibility that allows easy determination and implementation of ideal delivery models that improve client outcomes and value for money. This would include comfortably knowing when to purchase services, when to partner, when to deliver services directly, and when it would be appropriate to support client-directed funding.

Although contractual and collaborative relationships currently exist between the CCACs and their providers, the system is not sufficiently integrated and the contract levers do not yet exist to establish accountability for a payment model tied to health outcomes of patients. It is important to clear the way for new methods and break down existing procurement directives and regulations. This would include the ability to remove barriers to the procurement process and design new contracts in order to create new approaches to align and accelerate home and community care.
modernization. Such new approaches would include standard pricing, outcome-based payments, assigning volumes by geography and populations, bundled services, bundled payments, integrated care teams, and creating a single “home care” brand.

Conclusion

A sustainable healthcare system that addresses the future needs of all Ontarians has home and community care as its foundation. Increasingly, healthcare funders are exploring options for better value in delivery and determining priorities for how care is to be delivered. Patients and caregivers need to be part of this redesign process. With an aging population, increased prevalence of chronic diseases, and growing expectations of patients for the health system, the need for a new approach to home and community care has never been greater.

References