STRONGER CARE AT HOME, BETTER HEALTH CARE FOR ALL ONTARIANS

Recommendations to the new Ontario Health Teams

FALL 2019

ENDING HALLWAY HEALTH CARE

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Home Care Ontario, *the voice of home care in Ontario™*, is a member-based organization with a mandate to promote growth and development of the home care sector through advocacy, knowledge transfer, and member service. Home Care Ontario members include those engaged in and/or supportive of home-based health care. In Ontario, Home Care Providers are responsible for delivering nursing care, home support services, personal care, physiotherapy, occupational therapy, social work, dietetics, respiratory therapy, infusion therapy, speech language therapy and medical equipment and supplies in the home to individuals of all ages. An estimated 59 million hours of publicly and privately purchased home care service is provided annually across the province.

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PRAISE FOR THIS REPORT

"Many of the solutions to hospital overcrowding lie outside hospital walls. To deliver the better-connected, high-quality care patients and families deserve, it is essential to break down the siloes within the health system. Home Care Ontario offers recommendations that would strengthen home and community care and reduce overreliance on hospitals and emergency departments. We look forward to continuing our close collaboration with Home Care Ontario and other partners during the implementation of Ontario Health Teams."

–ANTHONY DALE, PRESIDENT AND CEO, ONTARIO HOSPITAL ASSOCIATION

"Home and community care services are strongly positioned to support the provision of quality care to clients across the continuum. Clients and their families want to receive appropriate services in the community, where they are close to loved ones and not in hospitals corridors or emergency rooms. Home Care Ontario has identified some of the important factors in providing essential and necessary care in the community through their timely recommendations. We will continue to work with Home Care Ontario and other critical partners to advocate for enhanced community services through a strong network of partnership, as we transform the Ontario healthcare system."

–DEBORAH SIMON, CEO, ONTARIO COMMUNITY SUPPORT ASSOCIATION

INTRODUCTION

Ontario's promise of high-quality, universal health care is a cornerstone of our province's success. Over the years, however, the health system has become fragmented, and the hospital-centric model of care that worked well in the post-war era, is no longer functional given the current age demographics of Ontario's population. As a result, hospitals are consistently functioning at well over capacity, and waitlists for home care services are stretched and growing. This puts the overall quality and level of health care provided to patients and their families across the continuum at risk.[1] The system must reform significantly in order to address the use of hospital care for health care needs that would be better managed in the broad home and community care sector.

The well-documented phenomenon of 'hallway health care' in Ontario has sparked a serious discussion and better understanding of the root cause for this systemic issue. Health care professionals evaluating the underlying issues conclude that, without the establishment of a broadly-based home and community system of care that includes family physicians and others, it is only a matter of time before an even higher percentage of our hospital beds and emergency departments (ED) will be used to care for people who should, and could, be living at home.[2]

In response to this hallway health care crisis, the Ontario government has announced an extensive restructuring effort that will redesign the health care system around the patient and establish a series of integrated care organizations across the province called Ontario Health Teams (OHTs). OHTs are a new way of designing and delivering health care services in local communities and will involve all health care providers such as hospitals, doctors, home care providers, and community support services agencies working together to deliver seamless care to patients.

The creation of OHTs offers a significant opportunity to create a health care system that is more efficient, effective, and accessible for patients.

There are important steps that can be taken to expand and leverage home care and community–based care that will improve the system and the patient experience. This starts by examining what represents good care in the home, and asking the key question:

Can Ontario's health system, be redesigned to give better, more comprehensive care at home so that Ontarians are able to avoid hospitalization altogether? From our perspective, the answer to this question is an unequivocal 'yes'.

In this paper Home Care Ontario makes a series of recommendations for new OHTs to consider. The Association proposes clear steps that can be taken to utilize more home-based solutions to begin the needed shift from a hospital-based system to one that focusses on supporting the patient at home. These steps would better support family physicians, enable more care to be delivered at home—where people want to be— and support patients and their families in the home setting, while allowing hospitals to focus on caring for patients with intensive acute care needs. Using the latest data and real stories from the front lines of care, this paper will demonstrate that with the following changes, more patients will be able to feel safe and comfortable at home:

01 Expand the types of care that home care providers can deliver at home;
02 Give professional home care providers access to electronic medical records;
03 Improve transition planning and widening the circle of care;
04 Allow home care to work directly with patients to schedule patient-centred visits and,
05 Increase the use of technology to remotely monitor patients.

Home Care Ontario believes that, with these changes, Ontario's new OHTs can begin to address the ballooning crisis of hallway health care and improve the patient's experience in their homes and communities. Achieving these goals will also allow for improved system synergy within OHTs, between home and community care providers, family physicians, hospitals, and all those working across the health care system to deliver optimized care to patients.

A FUNDAMENTAL CHALLENGE: THE CARE SETTING DILEMMA

Ontario needs a high-functioning system to care for people in the most appropriate setting that is equipped to deal with their health needs.

In Ontario, publicly-funded care is provided in a variety of settings: in people's homes and communities, in doctor's offices, in clinics or pharmacies, in long-term care homes or in hospitals, to name a few. However, problems arise when the appropriate care setting for a patient is not available. For example, if a hospitalized patient has recovered to the point where they are ready to leave the hospital, but adequate home care is not available for them, that patient will remain in the hospital. This back-up creates delays throughout the entire system and great distress to patients and their families.

Elsewhere, if a patient living at home cannot access a higher level of home care service to avoid the likelihood of a fall, it is very likely that the patient will have a fall, resulting in an avoidable ambulance trip to the local Emergency Department, where discharge can be delayed for months. If the broader health care system had been truly focussed on maintaining a patient, (wherever they are in the system) in the 'most appropriate setting', this avoidable hospitalization need not have occurred.

In every hospital, a fluctuating number of beds are occupied by patients whose expected discharge time has been excessively delayed. These patients may require an alternate level of care in long term care or access to higher levels of home care rehabilitative support. Ontario's home care providers do have the capacity to provide additional, on-going rehabilitative services for many higher needs patients at home, however they are not presently requested or authorized to do so. As a result of this situation, hospital bed management slows and hallway medicine is created. If more services were provided in the patient's home, it would prevent and avoid these unnecessary, lengthy and costly hospital stays for patients and their families.

HOSPITALS: THE MOST EXPENSIVE CARE SETTING

Health care costs are rising and consuming an ever-greater share of Ontario's budget.[3] But even with all this spending, the current system is unable to curb the rise of hospital congestion. That is because the right kinds of care—care provided at home which would prevent people from entering a hospital, and enable patients to leave hospital faster—are still not available.[4] More and more, people are relying on the most easily accessed form of care available—hospitals—simply because the Emergency Department is open 24/7. Even though the wait in the Emergency Department may be long for patients and families, they may not feel that they have any other options when they are sick or in pain.

The single most effective thing OHTs can do to address the rising cost and declining quality of care is to provide patients and families with alternate ways of accessing timely care in the community. This includes making care at home more available and accessible and to increase our systemic understanding of ways to help patients avoid hospitalization altogether.[5] Such steps would reduce the number of times people have to go to hospital for care that could have been provided in a more appropriate home setting.

Many ALC patients can be taken care of at home for far less than $500 per day.

OPPORTUNITIES TO PROVIDE MORE CARE AT HOME

In order to transfer more patients from hospital into a stable home environment, OHTs must increase access to preventive provision of good care at home and in the community. This section explores several opportunities for OHTs to begin making this critical shift from hospitals to home.

01 Expanding the types of care that home care providers can deliver at home

Shifting to a sustainable, patient-centric health system requires a fundamental rethinking of the types of care that can be provided at home. If the health care system is to improve patient experience and support non-acute patients in the home, it not only needs to make more hours of care available at home, it needs to support preventive community support measures, improve the ability of family physicians to order that care, and broaden the types of care that are provided in the home.

The majority of the home care work contracted by the government today is focused on short-term check-ins and simple tasks—bathing, medication checks, injections and wound care. While these services are important for many patients to maintain stability at home, there is also a great need to increase the breadth and complexity of care that offered in the home. The addition of more care for complex needs would increase patient satisfaction and result in fewer trips to other, more costly areas of the health system.

For example, in an effort to reduce costs and treat as many patients as possible, physiotherapy, occupational therapy and social work home visits have been greatly reduced over the past several years in favour of shorter-term nursing and personal support visits. This lack of attention to the benefits of longer-term rehabilitation and comprehensive social work support is limiting the home care system's ability to meet a patient's immediate rehabilitation needs. In many cases, it is those more intensive, customized types of home care—such as physical and occupational therapies, social work, speech language and dietetic treatment as well as the addition of more complex nursing and personal support—that stand a very good chance of preventing the health decline and hospitalization of a senior.

Home care providers employ PSWs, Occupational Therapists, Registered Dieticians, Physiotherapists, Nurses, Speech Language Pathologists and Social Workers. Despite these capabilities, professional home caregivers lack the authorization and funding to adequately respond to the real time critical changes taking place in their patients' health and social circumstances. These front-line workers repeatedly cite the limited nature of their home care visits as a top reason for their clients being readmitted to hospital.

A PLANNED DEATH AT HOME – JEFF'S STORY – TOLD BY A SOCIAL WORKER

Jeff was a 67-year-old home care patient diagnosed with Bulbar ALS. His speech and ability to communicate were affected from a very early stage in the disease. I had become involved early on in the disease, and had formed a relationship with him and his wife. As his physical health deteriorated, he lost his ability to speak. Jeff would often tell his wife that he looked forward to my visits and thanked me for the time I spent with him, discussing this very difficult time in his life.

As his Social Worker, I had the opportunity to discuss some of the challenges that he would face and encouraged Jeff to consider what he wanted during this final stage of his life. His wife was very supportive of his needs and provided the majority of his care, as well as working full-time. Early on in the disease, I educated them on caregiver burden and burnout and encouraged Jeff to consider allowing PSW's to assist with some of his care. Jeff was reluctant to admit he needed the extra care; however, he also understood the concern for his wife's health, and he was able to accept the help as his mobility and speech also deteriorated.

Jeff wanted to die at home. He did not want to consider any other options for his death. Since this was Jeff's wish, his wife wanted to ensure that she was able to care for his needs. Due to good planning, he was able to die peacefully in his home with help from nurses and PSWs to support his complex care needs. His wife was able to manage his care and although it was a difficult time, she was thankful that she managed his care with additional support from family, physiotherapy and respiratory therapists.

Over this time, I provided Jeff's wife with frequent emotional support through telephone access and texting. I called her following his death to provide bereavement and emotional support. As a member of the team that provided care to Jeff and his wife, I was happy that we were able to fulfill his expressed wishes to have a good death at home.

Keeping people healthy at home and out of hospitals will not be achieved through the use of home care services alone. There are a number of preventative services provided by hundreds of community support service agencies across the province that play a critical role in keeping individuals healthy and out of hospitals. These include supports such as meal programs, transportation, assisted living, and fall prevention programs. As financial investments for delivering more care at home grows, so too must funding for these crucial community supports.

EXPANDED AREAS OF CARE

Looking at other jurisdictions and demonstration projects underway right here in Ontario, there are numerous examples of new types of preventive home care that would result in better health stability for Ontarians and lower rates of hospital readmission.

Examples of types of care that can now take place at home include education and monitoring for patients with chronic obstructive pulmonary disorder (COPD), comprehensive dementia care for both patients and families, enhanced palliative care, comprehensive mental health intervention, physical and occupational therapy, cardiovascular care and, stroke rehab therapy.

Additionally, home care could be offered in many situations that currently require patients to visit hospitals or clinics for regular treatments (e.g. certain forms of chemotherapy, hemodialysis and IV therapy), taking further strain off the health system and improving patient experiences.

HOSPITAL TO HOME COLLABORATION

Can extended and repeated hospital stays be avoided? Yes. Stroke rehab is just one example of stronger home care resulting in better health care and a more efficient use of health system resources.[6]

An innovative Community Integrated Stroke Rehab program delivered by William Osler Hospital, the Central West LHIN, West GTA Stroke Network and 1to1 Rehab demonstrates the benefits of expanding the scope of care provided in the home.

Prior to the program, patients waited 6 days to access intensive stroke therapy. The program provided integrated stroke rehab in patients' homes and decreased acute hospital bed stays by 3 days, achieved a 12 per cent reduction in inpatient rehab admissions and achieved a 3 to 4-point improvement in the patients' COPM performance.

The architects of this innovative home care rehab program reported that they could do even more to help patients recovering at home if hospital to home protocols were more timely. PT, OT, and SLP assessments can be done much faster in a patients' home, reducing costs, delays and the number of times a patient needs to return to hospital.

Key Recommendation: *OHTs must expand the types of care that home care providers can deliver at home.*

02 Giving home care providers access to health records

Every day in Ontario, people are admitted, or readmitted, to hospital simply because their home care worker was unable to access their 'real-time' health records. Professional home caregivers are expected to be part of a patient's circle of care, but when staff cannot access a recent prescription change or treatment history, the ability to care for their patients suffers.

Clarissa is a complex patient requiring home care. At a recent visit, her Registered Dietician (RD) visits and notices unstable nutrient levels. The RD could assess and treat the problem but requires Clarissa's latest blood work to identify the appropriate course of action. In an effort to obtain the patient's blood, the RD calls the patient's doctor and the blood lab. No one is able to share Clarissa's blood work with the RD, who then has no choice but to send Clarissa to the Emergency Department for assessment and treatment.

Could this Emergency Department readmission have been avoided? Yes. Giving home care professionals immediate, real-time access to their patients' medical records shows how stronger, more connected home care would result in better health care for patients and a more efficient use of health system resources.

Randall is an elderly patient who requires insulin injections. Judith is his home care nurse. Randall visits his family doctor who changes his insulin prescription and calls it into the pharmacy. Randall forgets to pick up his new insulin dose and to tell Judith about the change. Without any way of accessing Randall's recent health record, Judith is not aware that his treatment plan has been changed. She continues to inject the previous insulin levels, which fails to achieve the optimum blood sugar levels for Randall, whose overall health suffers as a result.

Could this medication error and associated health risks have been avoided? Yes. In a stronger, more connected home care system, professional home caregivers would have greater access to their patients' medical records, leading to better health outcomes for patients and a more efficient use of health system resources.

Additionally, family physicians and Emergency staff have no real-time access to the substantial existing data base of home care records. This is a completely unnecessary situation, caused only by red tape and the limited use of assessments that could be reviewed and streamlined to identify the patient's actual needs for increased and integrated care in the home.

All health care practitioners, including professional home caregivers, should be able to access and update a patient's health record in real time through Ontario's digital portals. Timely information exchange is the backbone of an integrated system of health care that helps people stay at home longer and in better health. These significant information challenges must be addressed to empower families, patients and caregivers and ensure that the right care decisions are being made by those closest to the patient in real time.

Key Recommendation: *Empower all health care workers in OHTs to provide the best possible care for their patients by giving all providers real-time access to their patients' full medical records.*

03 Improving transition planning and the circle of care

When a patient is treated in hospital, whether for emergency medicine or scheduled surgery, the length of the hospital stay depends on several factors. In many cases improving the patent's transition from hospital to home will be enabled when a patient's family physician is empowered to access discharge plans and home care providers are better aligned with hospital discharge communication patterns to avoid discharge delays from hospital care.

When a patient is referred for home care, there is often insufficient information shared between the referring hospital medical team and the home care team. This communication barrier is cited by professional home caregivers as one of the most common reasons for a home care client to be readmitted to hospital for care that could have been provided at home. Transition (or discharge) planning from hospital needs to be aligned to reduce error and match the capacity and skillset of the home care system to the patient's own home environment. The best way to encourage this alignment is to integrate and involve home care providers and hospital Social Workers directly in hospital transition and discharge procedures.

Involving home care providers in hospital transition planning would reduce the duplication of effort in assessing a patient's readiness for home care and, more importantly, help coordinate discharge plans between hospital and home care so that patients get home faster and receive timely care. By involving the home care team at the beginning of an admission and increasing the amount of information being shared between hospital staff and home care teams throughout the patient's stay, the likelihood of a patient being readmitted to hospital will decrease.[7]

Frank is ready to be released from hospital on a Friday, but his home care needs require a mechanical lift and a PSW trained to operate it. Due to communication barriers and the lack of early social work involvement in the planning of the hospital transition process, the lift does not arrive in time and the wrong type of sling is delivered. The PSW Supervisor and PSWs all arrive at Frank's house to be trained by the Occupational Therapist. Upon discovering that the wrong equipment has been delivered, they have to reschedule the training and Frank remains in hospital while the situation is resolved.

Could this extended hospital stay have been avoided? Yes. This is an example where stronger home care connectivity with the hospital social worker would have resulted in a smoother discharge, better health care for the patient and a more efficient use of health system resources. If the home caregivers were part of Frank's circle of care and involved in the hospital planning process, they could have intervened to avoid a costly and delayed transition from hospital to home.

A successful example of this type of integration can be found in a partnership between Social Workers at Circle of Care and Mount Sinai Hospital. The *Social Work Care Navigator program* matches Care Navigators with patients and families who are nearing discharge and have complex medical and discharge planning needs. In this program Care Navigators act as a bridge from hospital to home and work side-by-side with hospital Social Workers to ensure a seamless transition. These navigators ensure a smooth transition from hospital by following their patients for anywhere from 30-90 days, and the patient outcomes have been very successful.

Key Recommendation: *OHTs should ensure that hospital and home care social work staff are involved in home care planning with patients and families in order to establish a strong plan for durable patient discharge to the home.*

04 Enabling home care service providers to schedule patient visits

To ensure more home care can be provided, OHTs should make better use of the valuable skills of the thousands of current professional home caregivers by overhauling the way home care visits are scheduled.

Currently, 'time-specific visits' are mandated by referral, resulting in peak periods of demand during mornings and evenings and an insufficient workload at times in between. As a result, PSWs have difficult schedules, and the system runs inefficiently. From a client-centered perspective, as well as a capacity lens, this makes it impossible for the home care system to be flexible with actual client needs and preferences. The scheduling issue has been cited as one of the main reasons for the current PSW shortage as staff leave the sector due to burn out.

Half of PSWs do not stay in the job for a full year. Of the 8,000 new PSWs who graduated from programs last year, only 4,000 will still be practicing at the end of their first year.

Home care providers have the knowledge and technology to deliver better care by supporting personalized scheduling with patient involvement. Home care providers are in regular contact with their patients, and could provide more thorough, patient-centred care to arrange staff schedules. Such a change would create travel and deployment efficiencies in the existing PSW workforce and would immediately reduce wait lists. It would also allow home care providers to build needed predictability into staff schedules, enabling home care staff to achieve the work-life balance essential to keeping them on the job. Most importantly, it would also give patients the ability to manage their appointment times and increase patients' satisfaction with the health care system.

Gerry has an abscess on his leg and visits his family doctor for treatment. The doctor lances the abscess, sends Gerry home and makes a request for a home care follow-up to change the dressing and monitor the wound. The LHIN asks a home care provider for a same day wound care visit. Within a matter of hours, a nurse is sent to Gerry's house for wound care. But upon arriving, he realizes that Gerry's wound is only a few hours old. It is too soon to change the bandages. The nurse must return the next day and his time wasted. Home care staff must be included in the circle of care in which appropriate patient information is shared in real time.

Could this unnecessary nursing visit have been avoided? Yes. If the home care provider had real-time access to medical records and the ability to work with the patient to schedule visits, they would have arranged to visit Gerry at the appropriate time This example shows how a more connected home care system would result in better health care for patients and a more efficient use of health system resources.

Home care providers are taking advantage of technology and adopting state-of-the-art scheduling systems. However, because the LHINs are currently responsible for scheduling, the real-time benefits of these technologies are not being felt by patients.

Simply put, it is time for home care providers to assume direct accountability for home care service scheduling thereby enabling their staff to be responsive, efficient, and patient centred.

Key Recommendation: *OHTs should make more efficient use of Ontario's home care system by allowing home care providers to utilize technology and be responsible for their own staff scheduling to meet patient needs and achieve good clinical care.*

05 Increasing the use of technology to remotely monitor patients

Chronic underfunding of Ontario's frontline home care sector over the past decade means that the province has not kept pace with technological developments that have the capacity to increase the quality and quantity of home care and further reduce the likelihood of hospital readmission. Greater investments in remote patient monitoring technology and real-time interactions with nurses, doctors and others in a patient's circle of care would give home care staff the tools needed to provide more frontline care to their patients and keep them healthy and happy at home for longer periods.

eShift – In London, the Southwest LHIN has introduced a smartphone app that connects nurses with in-home PSWs in real-time. The benefits are extensive. Through the direct connection to the supervising nurse, the home care PSW is a part of the direct circle of care—conveying patient information in real-time and modifying the treatment plan as prescribed by the nurse. Without this real-time connection, the PSW would not be able to raise immediate concerns about the need for changes to the patient's treatment, which could require care by a physician.

The e-Shift model is used to support patients with multiple complex conditions and those who are palliative and at end of life. In the eShift model, the PSW can consult the remotely-stationed supervising nurse who determines if a change in the home care plan is all that is needed to keep the patient healthy and happy at home. The introduction of the eShift app has decreased Emergency Department visits to the London Health Sciences Centre (LHSC) by 50 per cent and hospital readmission rates by 42 per cent among home care patients with chronic obstructive pulmonary disorder (COPD).[8]

The eShift program has been shown to reduce the likelihood that a palliative patient will be admitted to hospital in the final weeks of their life. Many patients with a terminal diagnoses express the wish to die at home, but in the end, are transferred to acute care because the family does not have access to enough home care services and supports to manage the final stages of life.[9] *With eShift, the nurse providing home care is electronically connected to a Directing Registered Nurse who is an expert in palliative care. By consulting the Directing Registered Nurse and adjusting the treatment plan to keep the patient and their family comfortable and informed, the likelihood of an unplanned and unnecessary hospital admission falls dramatically. With eShift involvement, less than 2 per cent of patients were admitted to hospital in the final weeks of their lives.*

When professional home care staff are supported by technology to link with other health care professionals in real time, the type and quality of health care in the home increases and hospital admissions are greatly reduced.[8]

Technological advancements have created great opportunities to transfer more care into the home and create better synergies with hospitals.

OHTs should increase the use of:

Educational apps and videos that teach patients the basics of self-care. Whether for positioning, wound care, exercise programs, dietary needs or specific health condition, videos and interactive applications can increase and engage a patient and families' understanding of the importance of self-care. Self-management leads to resilience that improves health and can reduce the need for hospital readmission. In cases where the app monitors a patient's activity levels or health indicators, patients report higher motivation in maintaining their treatment plan, which can also reduce the instance of hospital readmission.[10]

Telephone and videoconferencing check-ins. OHTs have an opportunity to leverage tele- and videoconferencing technologies to allow professional home caregivers to check in with more patients more frequently, ensuring they are on track with their treatments and are aware of the need for more support if new health issues arise.

Real-time video conferencing among health teams. Professional home caregivers can feel isolated and outside the circle of care. When a home care worker notices a sudden change in a patient's health, they have few options but to refer back to hospital or the family doctor. Alternatively, when they have easy access to the health care professionals responsible for the treatment plan, home care can become more proactive in assessing and treating changes in the patient's health. With real-time technologies that supports home care to connect with a patient's broader medical team, better health care can be coordinated from home.

Remote monitoring of patient vital signs and other key health indicators. Remote monitoring technologies have come a long way in a short time, and remote patient monitoring pilot projects continue to show great potential:

- Chronic Heart Failure (CHF) and COPD patients can be remotely monitored using tablets, blood pressure machines, saturation monitors and scales. In this scenario, patients receive calls from nurses who check on them on a regular basis, as well as when an alert is detected. This project reported a 73% reduction in Emergency Department trips and a 64% reduction in the number of hospitalizations.[11]
- It is now possible to remotely monitor a patient's cardiovascular implant, reducing the need for costly trips to the clinic or hospital.[12]
- A team at the University of Toronto is developing a wearable device to monitor COPD patients at home, checking for early indicators that a trip to hospital is on the horizon, such as shortness of breath, worsening cough or decreasing activity level.[13]

Remote monitoring technologies now make it possible for a home care team to have real-time data on their patients' activity levels, O2 levels, blood pressure, weight changes, and a host of other indicators. Combined with control over scheduling, these technologies give home care professionals the insight and flexibility to respond immediately to a change in a patient's condition, deploying resources where necessary to avoid hospital readmission.

Key Recommendation: *OHTs must utilize technological advancements to deliver more care safely at home and provide patients, caregivers and home care teams with greater access to medical tools, information, and inter-disciplinary consultation.*

CONCLUSION

Ontario's health system is facing significant demographic change that requires deep systemic change in the structure of the health care system. The provincial health care system is currently not balanced in terms of the provision of a robust system of care at home—but it does not have to be this way. Ontarians do not need to wait in hallways and accept rationed care. Ontarians do not have to settle for anything less than the high-quality care they deserve.

As the health system is transformed and OHTs are established, an opportunity exists to redesign the system in a meaningful way and create increased collaboration between hospitals, primary care home care providers, nursing, therapeutic and community support service agencies.

By shifting significantly more complex care to home care, enhancing community support services, empowering patients and frontline workers with real-time information and adopting the latest remote monitoring technology, OHTs can build a robust and sustainable, patient-centric health care system. OHTs should:

01 Expand the types of complex care that home care providers can deliver at home;
02 Equip home care professionals with real-time access to patient information through electronic medical records;
03 Improve transition planning – from hospital to home and within the health care system in order to widen and improve the circle of care;
04 Enable home care service providers to directly schedule staff to make patient visits; and,
05 Increase the use of technology to remotely monitor patients.

By achieving these recommendations in the development of OHTs, systemic collaboration and cohesion will allow for Ontario's health care system to truly work for the benefit of the patient and the province. These five steps can be taken right away to reduce backlogs and ease the current hallway health care crisis. As health system transformation moves ahead, and at every step of the way, this question needs to be asked: *Would a stronger home and community care system result in better health care for patients and a more efficient use of health system resources?* The answer is often yes, and the benefits for patients and their families—and the entire health care system—will be substantial.

Methodology: Thousands of frontline home care professionals are delivering millions of hours of care every year to Ontarians. In preparing these recommendations, Home Care Ontario turned to its patients' experiences and system partners in the hospital, community support and primary care sectors. Unless otherwise cited, the stories, anecdotes and recommendations in this paper were sourced directly from direct experience of frontline health care professionals practicing in the province.

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