Discussion Paper

Ensuring the Success of the Coordinated Delivery of Personal Support Services by CCAC and CSS Agencies

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Introduction

With the release of *Patients First: A Roadmap to Strengthen Home and Community Care* in May 2015, the Ministry of Health and Long-Term Care (MOHLTC) launched a series of initiatives to strengthen and modernize the delivery of home and community care in Ontario. The steps outlined in the *Roadmap* build on changes already underway, including plans to implement the coordinated provision of personal support services (PSS) by community support services (CSS) agencies and Community Care Access Centres (CCACs). CCACs continue to stress the importance of alignment across the initiatives that will affect the way personal support services are delivered to Ontarians. It is vital that we leverage all components of our home and community care system, with one point of access to the patient, in order to improve wait times and access to care for all patients. Our recommendations focus on ensuring two things:

- That Ontarians have access to a transparent, sustainable and easy to access system of care.
- That CCACs and community support service agencies are able to deliver on critical health system objectives and meet expectations.

Changes to PSS delivery were enabled by amendments in May 2014 to Regulation 386/99 of the *Home Care and Community Services Act, 1994*. The MOHLTC developed policy guidelines in April 2014 to guide service delivery and coordination.[1] The Local Health Integration Network (LHIN) Collaborative, working with LHINs and representatives from the CSS and CCAC sectors, is providing implementation planning and support. Care definitions and standards are in development, as are performance measures.

Early-adopter CCACs and CSS agencies will launch the shared delivery of PSS by January 2016, at the same time as the MOHLTC is planning to begin testing the initiatives outlined in the *Roadmap* that will also impact the delivery model for PSS. Therefore, it is essential to consider the alignment of all the changes that will impact the delivery of PSS. Such a proactive review will help ensure key objectives are met and that the testing of changes can be managed and evaluated.

To promote the optimal success of the new collaborative PSS delivery model, the OACCAC offers the following key recommendations to the PSS Regulatory Amendments Implementation Steering Committee:

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[1] "Policy Guideline Relating to the Delivery of Personal Support Services by Community Care Access Centres and Community Support Services Agencies, 2014" and "Policy Guideline for Community Care Access Centre and Community Support Service Agency Collaborative Home and Community-Based Care Coordination, 2014"

Recommendation 1: Coordinated planning – *Formally link the PSS Regulatory Amendments Implementation Steering Committee and provincial Roadmap advisory tables. Align planning for new initiatives and work together toward a clearly-defined, comprehensive and achievable goal.*

Recommendation 2: Appropriate timeframes – *Testing and implementation timeframes must align with related initiatives and allow learning from early adopter sites.*

Recommendation 3: Robust performance framework – *The performance framework must encompass capacity planning, agreed-upon service priorities, standardized quality monitoring, and a funding framework that reflects need in order to improve CCACs' ability to care for complex and post-acute patients.*

Recommendation 4: Leverage resources – *Build on existing infrastructure and assets, including CCACs' information technology infrastructure and integration with other health providers, and avoid duplicate structures and processes.*

Recommendation 5: Value for money – *Monitor the impact on unit costs and ensure the new model provides value for money before implementing province-wide.*

Recommendation 6: Single access point – *Use existing home and community care infrastructure and expertise to provide a single point of access and assessment.*

Recommendation 7: Workforce stability – *Monitor the impact of the new model on workforce stability and prepare a strategy to mitigate against personal support workers moving to jobs with lower-risk patients.*

Recommendation 8: Understand labour implications – *Prepare contingencies for the impact of the* Public Sector Labour Relations Transitions Act, 1997, *particularly on currently non-unionized CSS lead agencies.*

## A. Align planning and implementation of PSS change initiatives

Recommendation 1: Coordinated planning – *Formally link the PSS Regulatory Amendments Implementation Steering Committee and provincial Roadmap advisory tables. Align planning for new initiatives and work together toward a clearly-defined, comprehensive and achievable goal.*

Recommendation 2: Appropriate timeframes – *Testing and implementation timeframes must align with related initiatives and allow learning from early adopter sites.*

Creating a shared, collaborative delivery model for PSS by CCACs and CSS agencies is one of three major initiatives that will affect how Ontarians access and receive PSS in the near future. Two of the steps in the *Roadmap* — the creation of a Levels of Care Framework for home and community care and the plan

to offer self-directed care as an option for people receiving home and community care — will also directly impact and change how PSS are offered.

Figure 1. Changing the way Ontarians Access and Receive Personal Support Services
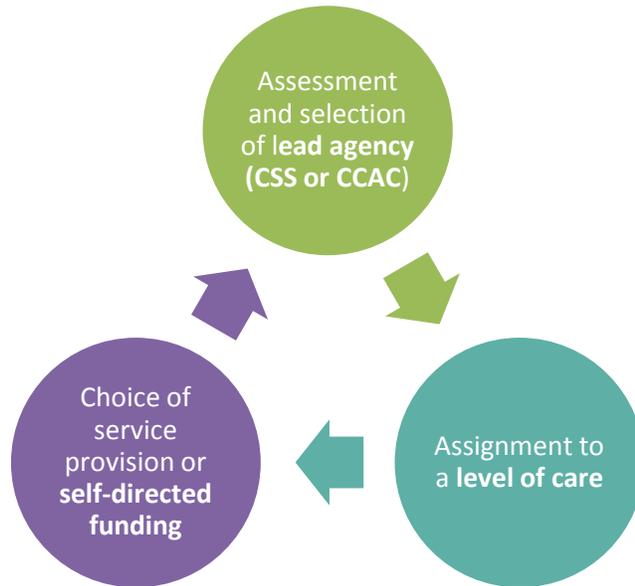
NOTE: Self-directed funding will be pilot tested in CCACs only

All three PSS initiatives share the goal of creating a more integrated patient-centred care system that is easy to access and equitably available across the province. A key objective for all these initiatives is increased transparency to make it easier for people to access the care they need and understand what they can expect from the home and community care system.

Planning for early adopter sites for the collaborative delivery of PSS by CCACs and CSS agencies is underway, with the selection of lead CSS agencies and the establishment of local leadership tables to guide implementation beginning this fall. Full provincial implementation of the shared delivery model is planned by March 2016. At the same time, the ministry has established a provincial advisory committee and working groups to oversee the implementation of the *Roadmap*, including the Levels of Care Framework and self-directed funding.

All three PSS initiatives focus on the same patient populations and will be tested and implemented between now and 2017 (see Figure 2, below). All 14 CCACs will be involved in implementing the new models over the next one to two years. The three initiatives will have interrelated impacts on how patients and families access and receive services, and how information about PSS is conveyed to the public and to prospective patients.
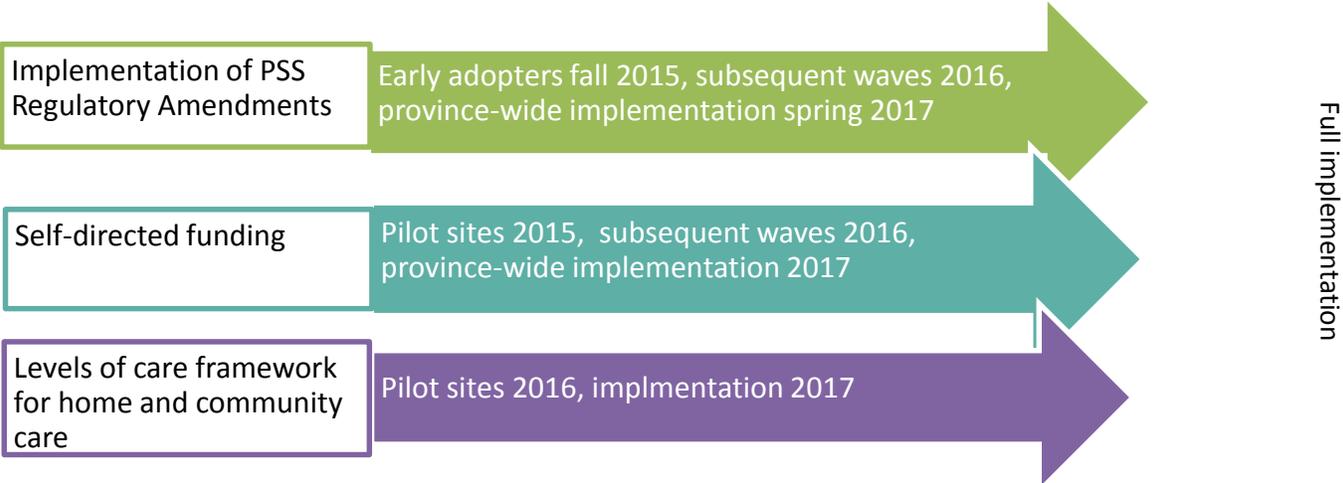
Careful alignment of planning, testing and roll-out of these three initiatives is critical to their overall success. A clearly defined goal that considers the total transformation of PSS delivery is needed.

Reaching that goal will require sequenced steps to ensure changes are coordinated and manageable for the organizations involved. It will also be important to ensure that evaluation and performance planning accurately account for both the separate and combined contribution of these changes to outcomes, including the experience of patients and families, as well as overall value for the health care system.

Contingency planning for course corrections should be in place in the event that any changes are not achieving the desired objectives or standards of care. The schedule for the phased implementation of the shared delivery of PSS should include time to absorb lessons learned from the early adopter sites. It is also essential to ensure that provincial roll-out of the shared delivery of PSS will not compromise the ministry's public commitments in the *Roadmap* to implement a Levels of Care Framework, self-directed funding and other steps that affect the delivery of PSS.

Aligned communication about all the changes to PSS will be critical to ensure patients and the public have accessible, clear, consolidated information that helps them easily understand how to access care and what they can expect from the home and community care system.

Figure 2. Implementation Timeframe for Change Initiatives Affecting the Delivery of Personal Support Services

Implementation of PSS Regulatory Amendments — Early adopters fall 2015, subsequent waves 2016, province-wide implementation spring 2017

Self-directed funding — Pilot sites 2015, subsequent waves 2016, province-wide implementation 2017

Levels of care framework for home and community care — Pilot sites 2016, implmentation 2017

Full implementation

B. Achieving the desired policy objectives

Recommendation 3: Robust performance framework – *The performance framework must encompass capacity planning, agreed-upon service priorities, standardized quality monitoring, and a funding framework that reflects need in order to improve CCACs' ability to care for complex and post-acute patients.*

The initial intent of amendments to the PSS regulation was to strengthen CSS capacity to support older adults who are relatively independent and to improve the ability of CCACs to focus on patients with complex and post-acute needs. CCACs and CSS agencies will be expected to "collaborate as one sector to

coordinate and optimize home and community care for older adults with frailty or long-term chronic conditions to support them in living safely and independently in the community."

Early planning to support these objectives has focused on reaching agreement on common definitions, standards of care and shared performance measures for CSS agencies and CCACs. The implementation team is developing a conceptual framework that, at this point, includes the following policy goals:

- Person- and family-centred care
- Equitable, accessible care
- Consistent home and community practices
- High-quality care and better value for money
- Integrated care

In the planning to date, there has been a significant and necessary focus on building the capacity of CSS agencies to deliver PSS through selected lead agencies. Less clear in the conceptual planning is how CCACs will be supported to strengthen their ability to care for complex and post-acute patients. Consistent capacity planning, a funding framework and clear priority setting are critical to achieving all objectives in a balanced way. A framework to support a planned approach to funding CCAC and CSS personal support services is needed — one that enables seniors with lighter needs to access services that promote their health and independence, while also ensuring that funding for the growing number of people with chronic health problems and complex needs is not jeopardized. It is important that the amount of care provided is reflective of patients' needs and that stable, seniors with low care needs do not have access to higher levels of service through CSS agencies than moderate to high-needs seniors served by CCACs. The Personal Support Algorithm, a newly developed output of the RAI assessment, can be used system-wide to support consistent decision-making about levels of PSS. Ultimately, service levels should be consistent with the Levels of Care Framework.

Finding the right balance is essential to managing broader system pressures, including reducing emergency room wait times and hospital Alternate Level of Care (ALC) days, and ensuring that caregivers at the highest risk for stress and burnout have the support they need.

At this point, decisions about how to fund the implementation of — and ongoing changes to — the shared delivery of PSS is the responsibility of each of the 14 LHINs, with an acknowledgement that LHINS will need to monitor provincial variations. Should implementation proceed in the absence of coordinated capacity planning, clear service priorities and a strategic funding framework, there is significant risk that regional inequities and inconsistencies in service delivery will be amplified and the needs of complex patients will not be addressed in planning.

It is also important for equity and quality of care that performance standards and quality improvement be consistent across CSS agencies and CCACs. This would include Quality Improvement Plans, assessment tool training and ongoing competency testing, as well as service priority and service delivery guidelines.

C. Achieving quality and value for patients and the health care system

Recommendation 4: Leverage resources – Build on existing infrastructure and assets, including CCACs' information technology infrastructure and integration with other health providers, and avoid duplicate structures and processes.

Recommendation 5: Value for money – Monitor the impact on unit costs and ensure the new model provides value for money before implementing province-wide.

Recommendation 6: Single access point – Use existing home and community care infrastructure and expertise to provide a single point of access and assessment.

Recommendation 7: Workforce stability – Monitor the impact of the new model on workforce stability and prepare a strategy to mitigate against personal support workers moving to jobs with lower-risk patients.

From a value-for-money perspective, one key measure of success will be the ability of the new collaborative care model to maintain or expand the volume of personal support services delivered at no more than the current overall unit cost of care. To achieve this goal, it will be important to find the right balance between creating new capacity and ensuring compliance with service standards, while avoiding any unnecessary duplication of infrastructure and processes. Harmonized provincial rates for the delivery of PSS should apply to both CCAC and CSS providers to ensure equity.

CCACs have established broad system-level connections with other health-system partners, including hospitals and family physicians, to facilitate integrated care and patient transitions. CCACs provide a single, coordinated point of access that provides comprehensive assessment by a health care professional and service planning for extended hours, seven days per week. The new model for PSS is based on the assumption of multiple points of access ("any door is the right door"). At the first point of access, patients will be screened and directed to either the CCAC or CSS agency to complete a comprehensive assessment. The model will require lead CSS agencies to develop extended hours of access and the skills and capacity to identify to full range of patients' health and support needs at the initial screening. If the initial screening by a CSS agency does not identify all health care needs, there is risk that patients will not receive the professional health care services that they need, or that duplicate assessments will be required.

CCACs have also developed information technology infrastructure to support a common electronic patient record, integrated assessment information and performance-management systems. These assets can be leveraged to achieve the overall objectives for collaborative PSS delivery — without the need to create parallel mechanisms at a greater cost to the system.

In addition to providing a common electronic patient record, the CCAC Client and Health Related Information System (CHRIS) provides e-referral, centralized waitlist management, integrated assessment and care planning, and a secure mechanism for sharing patient information electronically. The information collected in CHRIS and shared with the ministry, LHINS and other health system partners

provides data that informs regional planning, performance measurement and provincial funding allocation methodologies, including the Health-Based Allocation Methodology (HBAM) and quality-based payments. Although CCACs have no mandate to collect and manage information related to the delivery of services through CSS agencies, with the appropriate partner agreements and program funding, CHRIS could be leveraged to support the delivery of PSS services system-wide, ensuring that critical information to support broader health system planning and monitoring continues to be available.

Personal support worker wages and benefits are, and should be, the primary contributor to unit costs for PSS. One of the *Roadmap* initiatives focuses on continued efforts to improve personal support workers' wages and other supports to enhance the stability of the workforce. The availability of a skilled, stable workforce contributes to high-quality care and a positive experience for patients and families.

Another key success factor in the new collaborative model for PSS will be ensuring workforce availability and stability across the full continuum of care. This goal includes the ability to recruit and retain skilled personal support workers who are interested in working with complex, heavy-care patients, including those with cognitive challenges and difficult behaviours.

One challenge with the current contract model for PSS is that CCACs have limited ability to control the wages, benefits and employment arrangements of front-line providers, including personal support workers. CSS providers will have a greater level of control in setting personal support worker compensation and employment conditions. There is a risk that personal support workers may migrate to jobs that allow them to work with lower-risk seniors who do not have heavy-care needs or behaviour problems. Stakeholders will need to monitor carefully and consider mitigation approaches to ensure that the new collaborative model does not have unintended consequences in terms of workforce availability and stability.

D. Ensuring readiness for labour transitions

> ***Recommendation 8: Understand labour implications –*** *Prepare contingencies for the impact of the* Public Sector Labour Relations Transitions Act, 1997*, particularly on currently non-unionized CSS lead agencies.*

The transition of responsibility for assessment, care planning and care coordination for lower-needs patients who require PSS from CCACs to CSS agencies will likely fall within the scope of a "health service integration" as defined in the *Public Sector Labour Relations Transition Act, 1997* **(**PSLRTA). The majority of CCAC care coordinators and other staff are unionized, as are some of the agencies that provide personal support services through contracts with CCACs. It is reasonable to anticipate the bargaining agents for these staff will be interested in pursuing similar bargaining rights in the CSS agencies as implementation of the regulation amendments proceeds. The roll-out planning for this initiative needs to consider the possible impact of PSLRTA, particularly for CSS lead agencies not currently unionized. Certification may be less of a factor in the early stages of adoption when service volumes are low, but as full implementation proceeds, so will the likelihood of a PSLRTA application.

PSLRTA as originally enacted in 1997 provided a legal framework for unions and employers during large-scale amalgamations in the municipal, education and hospital sectors. Because most of these sectors were unionized, mergers and restructuring brought multiple and often-competing trade unions with different collective agreements together. PSLRTA provides a method to resolve any competing interests.

In 2006, PSLRTA was amended to have a broader application to the health sector. In accordance with the new Section 9, a union or an employer who is subject to a "health service integration" can apply to the Ontario Labour Relations Board (OLRB) for an order declaring PSLRTA applies. Health services integrations are defined broadly to include any change to the provision of programs or services, including but not limited to "dissolution, amalgamation, division, rationalization, consolidation, transfer, merger, commencement or discontinuance" involving employers who are "health service providers" within the meaning of the *Local Health System Integration Act, 2006* (LHSIA). CCACs and CSS agencies and other employers whose primary function is the provision of health services are included.

Complementary provisions in LHSIA provide additional guidance on the application of PSLRTA for health service integrations. Specifically, they indicate that PLSRTA applies in the case of:

- The transfer of all or part of a service (of a person or entity) under an integration decision
- The transfer of all or most of the operations of a health service provider under a minister's order, or
- The amalgamation of two or more persons or entities under the authority of a LHIN integration decision or a minister's order

With this expanded definition, unions are able to apply to the OLRB for PSLRTA declarations when services are transferred to non-unionized employers or employers with different bargaining agents. The OLRB has the authority to redefine bargaining units and order votes of employees to determine their bargaining-agent preferences. PSLRTA allows a union to follow its bargaining rights to the new employer/service provider. In addition, once PSLRTA has been declared to apply, previously non-unionized employees can get swept into a newly-created bargaining unit and employee seniority may be recalculated in accordance with the Act. The potential impact of PSLRTA could be reduced if *Recommendation 6* was adopted and CCACs continued to provide the primary point of access and assessment for PSS.

Summary

Ontario is embarking on an ambitious agenda to strengthen and modernize home and community care. A number of interrelated components of this plan will transform the provision of PSS for people with long-term support needs. To ensure success, an integrated approach to design, implementation planning and evaluation that considers the logical sequencing of activities, anticipates risks and plans for mitigation is essential. The result must be an integrated model of care that is easy for patients to understand and access. The recommendations are offered to help ensure the success of collaborative care delivery of PSS by CSS agencies and CCACs in the context of the broader transformation of home and community care.