

ONTARIO NURSES' ASSOCIATION

SUBMISSION ON HOME AND COMMUNITY CARE IN ONTARIO RESPONSE TO THE MINISTER'S DISCUSSION PAPER

Ministry of Health and Long-Term Care Discussion Paper - Patients First:
A Proposal to Strengthen Patient-Centered Health Care in Ontario

February 29, 2016



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INTRODUCTION

The Ontario Nurses' Association (ONA) is the union representing 60,000 Registered Nurses (RNs) and allied health professionals, as well as more than 14,000 nursing student affiliates, providing care in hospitals, long-term care facilities, public health, the community, clinics and industry.

We welcome the opportunity to provide frontline nursing input to the Minister's Discussion Paper on restructuring home and community care.

ONA represents approximately 3700 employees in 10 of the 14 provincial Community Care Access Centres (CCACs). ONA is the exclusive bargaining agent for the vast majority of the frontline Care Coordinators.

ONA's members in the CCACs are a broad and diverse professional group. The vast majority of our members are RNs, Nurse Practitioners (NPs), Registered Practical Nurses, Care Coordinators, Social Workers, Occupational Therapists, Physiotherapists, Long-Term Care Placement Coordinators, Rapid Response Nurses, Nurse Clinicians, Advanced Practice Nurses, Nurse Educators, Consultants (such as palliative, wound care, etc.) and allied health professionals. Care Coordinators constitute a very large proportion of ONA's bargaining units. Those occupying this role must, as a job requirement, be a regulated professional, such as an RN or allied health professional. Other health professional roles are also in the ONA bargaining units. ONA also represents clerical and administrative employees in the one CCAC where ONA represents an all-employee unit.

A MODEL FOR HOME CARE SERVICES

In previous submissions to the Ministry, ONA has documented the costs of care under the current competitive bidding procurement model. We have shown the duplication of services and management in the delivery of home care and the lack of continuity of care for patients and their families. We proposed a model for the integration of care delivery into CCACs whereby efficiencies and client quality would be realized.

Our vision is a single public agency for home care delivery in Ontario. This agency would directly employ and manage all employees involved in the delivery of home care.

ONA has also identified the need for additional funding and capacity within CCACs to meet the growing demand for home care services as demonstrated by the lengthy wait list for services.

The Minister's Discussion Paper, *Patients First*, is limited to addressing only the structural component of which government organization will be responsible for planning and home care coordination, not the actual delivery of home care services. The Paper does not address the underlying funding and capacity issues.

The frontline Care Coordinators that ONA represents inform us that the current complement of staff are challenged to manage existing caseloads. Without expansion, CCACs do not have the capacity to coordinate home care to meet growing patient needs. We believe the government must provide a policy response to improve accountability, transparency and quality of care in the home and community care sector. This is required, in addition to expanding capacity to meet patient needs. As the province's Auditor-General detailed in the most recent December 2015 Annual Report, the home care sector, which once was intended to service clients with low-to-moderate care needs, "now serves clients with increasingly more complex medical and social-support needs."¹

The Discussion Paper acknowledges what ONA has argued for many years, i.e. that there are significant gaps in care and capacity in the community. Home care and community services are inconsistent across the province. ONA's position is that these gaps and inconsistencies are a direct result of understaffing and underfunding of the CCACs, as well as home-care and community health care services.

In an attempt to reduce costs to the healthcare system, the provincial government has shifted resources to the home care sector to keep people in their homes longer. However, for ONA, restructuring the home care sector is not merely a matter of better administrative integration and the deletion of unnecessary duplication of services and management. While these issues are important, there is also a need for increased funding and increased staffing to meet the increasing needs of the sick, frail and elderly in their homes and to ensure high quality care.

As part of an improved model, a first step would be to ensure that there is total coordination of care by Care Coordinators.

An equally significant issue is that Ontario has witnessed the proliferation of non-unionized, for-profit, lower-wage home-care and community service providers which does not advance the quality of home care in the province. In fact, the Auditor General was not even able to determine the actual costs of care delivery because of commercial confidentiality.

The Discussion Paper proposes that home care services would continue to be provided by current service providers. This proposal seems to ignore all of the evidence on duplication and inadequate service provision. Agencies which are not providing adequate service and/or not fulfilling their contract obligations in the current CCAC model continue to be rewarded with patients being assigned to them. This significantly increases the work and follow up for the Care Coordinators who seek to ensure patients are receiving timely, consistent quality services. The referrals sent by Care Coordinators are not fulfilled in a timely fashion, often as a result of retention and recruitment issues in the provider agencies. However, there are no repercussions for the service providers. How will this change if there is no change to the service providers under the proposed model?

Continuing with the existing contract for service model for service providers does not address the obvious inefficiencies and thrown away costs of the managed competition model. Significant resources are necessary at both the contractor and "contractee" end to operationalize the Request for Proposals (RFP) process that is now in place. Having the Local Health Integration Networks (LHINs) step into the shoes of the CCAC is not going to reduce this waste of resources. A model in which the LHINs directly employ all of the frontline health care workers, rather than just a portion of them, would be a much better use of health care human resources and would eliminate the needless expenditure of resources on the RFP process. It would also result in much better continuity of care and setting of consistent standards across the system. Finally, by dispensing with the current fragmentation of services between the CCACs and the contracted service providers, there would be a significant increase in proper accountability and transparency for clients and the public.

The Discussion Paper indicates that LHINs will undertake health human resources planning. ONA is calling for funding and development of a multi-year nursing human resources plan, for implementation and tracking by the LHINs, targeted to reduce the significant gap in the RN-to-population ratio between Ontario and the rest of Canada. Structural change will not be sufficient without the necessary staffing to meet the growing demands for home care services. A key funding issue is comparable compensation for NPs in primary care, home care and long-term care with NPs in acute care. We understand that there was a recent announcement in Budget 2016 for funding for NP compensation in primary care: however, we are not aware if this applies to CCAC, homecare and long-term care NPs?

GAPS IN THE DISCUSSION PAPER

While the Discussion Paper appears to acknowledge the massive duplication of services and resources utilized in CCACs and in provider agencies to manage the existing contracting process, the focus seems to be on ensuring a standard basket of home care services to be delivered regardless of which area of the province is involved. The focus is on making home and community care more consistent and more accessible - easier to navigate for patients and families.

The discussion paper does not address the multiple layers and number of CCAC management positions that did not reduce with the merger of the 43 CCACs into the 14, as expected. In this proposed restructuring, we would expect significant reductions in management positions and that funding be reinvested in patient care.

The Discussion Paper proposes to transfer "all CCAC functions" into the LHINs. This means that the LHIN Boards would govern the delivery of home and community care. The CCAC Boards would be dissolved. While ONA supports this transfer to LHINs because it maintains home care coordination and planning within a public organization, we have significant concerns regarding how this will be rolled out. Much of the detail is missing from the Discussion Paper.

The Discussion Paper proposes that Care Coordinators would be focused on sub-LHIN regions. However, the Discussion Paper does not provide a proposal for sub-LHIN regions.

The Discussion Paper also proposes that Care Coordinators may be deployed into community settings. Again, the paper does not provide details on how this deployment would operate in practice. Nor does it address the issue of who the Employer would be in this model. It is feasible to imagine that the LHIN sub-regions could in fact be the hospital and the surrounding catchment areas.

The Discussion Paper does not address how Health Links, Bundled Care and/or Primary Care will be incorporated into the proposed model. Further, the Discussion Paper does not make any proposals regarding the linkages and overlap between restructured home care coordination and delivery with other reforms underway such as Health Links, funded Bundled Care projects or other proposed primary care reforms.

For example, for patients with multiple conditions and the most complex care needs, the government has expanded the community Health Links projects, which are local interdisciplinary teams, from 69 to 82 across the province. When the government announced Health Links in 2012, the announcement said that Health Links will encourage greater collaboration between existing local health care providers, including family care providers, specialists, hospitals, long-term care, home care and other community supports. Further, all Health Links will have a coordinating partner such as a Family Health Team, Community Health Centre, Community Care Access Centre or hospital. Obviously, there appears to be a fair amount of overlap or duplication between Health Links and the proposals being made in the Discussion Paper.

The government also announced funding in 2015 for six Bundled Care projects. As explained in the government's announcement, the bundled care model provides a single payment to a team of health care providers to cover care for patients both in the hospital and at home. These teams focus their work on patients who require short-term care at home after leaving hospital. Again, it appears that there is duplication between these bundled care funding models and the proposed restructuring of home care coordination outlined in the Discussion Paper.

Similarly, the government has received recommendations regarding primary care reforms, particularly the Price-Baker report. The government's position to date has been that the objective is to empower patients, not create additional administration. So, we wonder how the proposals related to primary care in the Discussion Paper achieve this objective when there appears to be another level of administration through the LHINs that is being proposed.

Under the current model of CCACs, service provider agencies are given a number of visits and/or patients randomly based on a computer program with no regard to geography, patient preference or patient continuity of care. Care Coordinators are receiving little reporting back about patient needs and/or changes in their condition until it is too late to effectively alter the course of treatment. In some cases, Care Coordinators are not notified of discharged clients thereby increasing the costs of care.

The Discussion Paper proposal does not address this fragmented delivery of home care services, nor does it discuss how accountability will be enforced.

The Discussion Paper does not address any of these issues related to the provision and fragmentation of home care services by multiple for-profit providers.

CONTINUITY OF CARE

Under the current care coordination model, CCACs do not provide full care coordination for patients; neither public health nor primary care are included. In the transfer to LHINs, ONA is calling for the expansion of care coordination to coordinate the full range of care needs for clients both in home and in community care. ONA advocates for the coordination of care across all sub-sectors of health care including public health and primary care. Until this is done, there will be inefficiencies and gaps in continuity of care. The frail and the vulnerable will fall through these gaps ultimately resulting in further costs to the system. Under the model proposed in the discussion paper, with the continuation of current service providers, it is particularly essential that each patient's care fall fully under the control of a Care Coordinator.

The Discussion Paper proposes more effective integration and seamless links with primary care and other health services. ONA endorses this and believes that an expanded role for Care Coordinators is a critical component of this more effective integration; seamless links with primary care and other health services are necessary for home care patients.

The Discussion Paper proposes stronger links with public health: LHINs would be responsible for accountability agreements with public health units and Ministry funding for public health units would be transferred to LHINs for allocation to public health units.

Current governance of public health units would remain in effect and local boards of health would set budgets; services would be managed at the municipal level.

ONA asserts that in order to maintain consistency in public health services, public health should become 100% provincially funded in the transfer to the LHINs for allocation to the public health units. This would ensure provincial funding and provincial standards for local delivery of public health services.

There is evidence from the literature that shows when Care Coordinators are able to coordinate a full range of services for the frail elderly based on need, the use of hospital emergency, acute care and long-term care declines.² It appears to us that an evolution is required in the transition to LHINs with a clear redefinition of care coordination as full care coordination based on patient needs throughout the entire health care system. This would mean that additional paramedic support to check on chronic high-health care users could be redirected back to the CCAC Care Coordinators who know their patients and their health care needs. This would also promote continuity of patient care.

In the current CCAC model, Care Coordinators complete the patient assessment and determine the care needs for patients to be kept safely in their homes and not require re-hospitalization. However, the costs are controlled by managers who have the ability to deny required services. How will this change in the transition to LHINs? Care Coordinators are health care professionals who know when there are differences in their patients' needs and should be able to assess and make decisions accordingly. The critical role of the Care Coordinator has been jeopardized by extreme increases in volume. As a consequence, at-risk chronic patients whose care used to be managed through periodic follow up visits, has been lost and patients are presenting in emergency.

One of the flaws in the existing care delivery system is the use of "best practices and care maps" which may be a practical application for the majority of defined groups of patients but may not be flexible enough to address the needs of all as they do not coordinate the full care required by individual patients. These "best practices and care maps" do not address co-morbidities and the individual needs of patients: this requires the professional assessment skills of Care Coordinators. The coordination of care of individual clients should be at the center of care assessment and delivery.

Our members report that care is fragmented in the current CCAC model as there is no single point of access to Care Coordinators. This should be corrected in any restructuring.

To ensure an integrated patient care model which works, it is critical to provide guidance on appropriate patient caseloads for Care Coordinators and to adjust for the increased workload and time it takes to make an integrated and coordinated model of care work. This needs to include integrating community support services such as Meals on Wheels, day programs, and transportation. The model also needs to ensure that seniors are not just given multiple pamphlets and, if something needs to be cancelled or rearranged, a senior is not left trying to navigate a confusing system.

LABOUR RELATIONS ISSUES RAISED BY THE TRANSFER TO LHINS

The Discussion Paper proposes that CCAC employees "providing support to clients" would be transitioned to and employed by the LHIN. ONA takes this to mean that all current unionized CCAC employees would be transitioned. This would include Care Coordinators and Long-Term Care Placement Coordinators together with the employees who provide clerical and administrative support. In addition, we assume that employees in more recent direct care roles will be transitioned; this would include, for example, Rapid Response Nurses, who provide the first in-home nursing visits to patients with high-risk conditions within 24 hours of being discharged from hospital. These direct care nurses are helping patients with the transition from hospital care to home care to reduce the risk of readmission and have been well received. We also assume that Palliative Care Nurse Practitioners and other health care provider roles currently directly employed by the CCACs would be transferred to the LHINs. The transfer of CCAC employees to the LHINs raises a significant number of labour issues which are not addressed in the Discussion Paper. We outline some of our labour concerns below.

Currently, the LHINs are prescribed as "Crown Agencies" within the scope of the *Crown Employees Collective Bargaining Act (CECBA - Regulation 386/07: Prescribed Crown Agencies)*. If that remains the case under any model in which the LHINs become the successor employer, the result will be that their employees will be subject to a legislative regime that is distinct from what they are accustomed to in the CCACs. This will have a number of labour relations implications.

Status of Employment

Will the new LHINs employees be public servants under the *Public Service Act of Ontario*?

Successor Rights

Currently, any restructuring of CCACs is covered by the *Public Sector Labour Relations Transition Act* (PSLRTA).

The *Local Health Integration Act* (LHIA) mandated that the 43 CCACs were consolidated into the 14 existing CCACs and that PSLRTA be applied to the consolidation.

Section 5.1 of PSLRTA specifically states that the Crown is not a successor employer for the purposes of this Act. Without an amendment to this provision, PSLRTA will not apply to the proposed restructuring of the CCAC as the work will be transferred to a Crown agency. The same will be the case if the work is subsequently transferred to another employer, even if that employer is not a Crown agency. Rather, Section 69 of the *Labour Relations Act*, the sale of business provisions, will apply to both types of transition.

That raises a number of concerns. Under Section 69, the LHINs would assume the same position as the CCACs in respect of any existing collective agreement or bargaining obligations. Essentially, the LHINs will step into the shoes of the CCACs in respect of any of the rights and obligations of the collective agreement.

However, the provisions of Section 69 are limited and do not give the Ontario Labour Relations Board (OLRB) the same powers to address potential issues arising in a transition. For example, under PSLRTA the OLRB has the power to determine appropriate bargaining unit descriptions in a merger or integration. Under Section 69, the Board's power is limited to correcting any inconsistencies in "like" bargaining units.

ONA's estimates are that each LHINs currently employs approximately 30-50 employees who are not represented by a bargaining agent; many of these appear to be non-union. A failure to include the current LHINs employees in the new bargaining units would result in fragmentation and potential jurisdictional disputes. It would not be conducive to a smooth transition or future harmonious labour relations.

Accordingly, existing bargaining unit descriptions will need to be modified to ensure that they are appropriate for the new circumstances when the LHINs absorb the CCACs. To achieve this the parties may require the intervention of the Board to deal with any differences regarding bargaining unit descriptions.

On the question of which bargaining agent will represent which unit, it is anticipated that there will be essentially no disputes arising from the integration of the CCACs with the LHINs. It is anticipated that there will be a transfer of existing bargaining agents with no need for the runoff votes prescribed under PSLRTA. Furthermore, due to the ratio of unionized employees in the CCACs to the number of non-union employees in the LHINs, it is anticipated that there will not be a need for a vote to determine the non-union option.

PSLRTA does have, however, a number of other provisions that would be helpful in addressing potential issues that could arise in the integration including the determination of seniority rights, the term of collective agreements, the rights of currently non-union employees and other matters. PSLRTA was specifically drafted to deal with successor rights in the public sector generally and with health care integrations in particular. There is no rational basis on which to exclude this health care integration from the same framework. If the parties can agree on a resolution of any issues that arise, that is the most desirable outcome. However, the provisions of PSLRTA should be used to give guidance to the parties in resolving issues and a mechanism to resort to for any issues that remains outstanding.

Collective Bargaining Dispute Resolution Mechanism

CECBA is premised on a right-to-strike with essential service agreements negotiated for the duration of a strike/lock-out. If not declared essential, all other workers have the right-to-strike. CECBA was drafted on the basis that it would apply to those employees who work directly for the government. It also applies to a number of Crown agencies such as the LCBO. It was not drafted through the lens of the health care sector.

It is the very firm position of ONA that the essential service provisions of CECBA are not appropriate for application to the proposed LHINs as employers of the current CCAC workforce. As is stated in *Patients First*, these workers are "essential." If they are essential and essential workers are not allowed to strike, the right to strike becomes meaningless.

ONA is not prepared to accept a model in which only a small proportion of their members would have the right to withdraw services in order to resolve collective bargaining disputes.

In the winter of 2015 (the last round of bargaining) 9 out of 10 of ONA's bargaining units in the CCACs voted to go out on strike. The strike had such a devastating effect on the provision of health care in the province that the Minister of Health intervened within a few days. The parties were forced to resolve their dispute through arbitration. The impact on the health care system was not simply the removal of services from the very vulnerable and often very ill patients in the home care sub-sector. It also resulted in backups in hospitals and long term care homes. Care co-ordination is essential to facilitate the movement of patients out of hospitals and back into the community and into long-term care homes.

As the health system becomes more and more integrated, the labour relations of the workers should also be integrated. ONA members working in the hospital and long term care sector do not have the right to strike due to the essential nature of their work and potential disruption to the health care system of a cessation of work. ONA takes the position that the same considerations apply to the community sector generally and to the work of CCAC workers in particular.

Grievance Arbitrations

ONA's members who work in the CCACs are currently covered by the *Labour Relations Act*; this means that their grievances are heard by an arbitrator (or panel) constituted in accordance with the provisions of the LRA and the applicable Collective Agreements. In this regard, they are subject to the same model as their colleagues in other sub-sectors of health care. However, were they to be brought under the CECBA regime their arbitrations would be heard at the Grievance Settlement Board (GSB). This causes ONA significant concern for a number of reasons:

- The GSB was set up to deal with the grievances of workers employed directly by Ontario or provincial crown agencies; they do not have expertise in dealing with issues arising in the health sector. That expertise lies with arbitrators chosen by the parties to the health care Collective Agreements where a jurisprudence has been developed to respond to those issues.

- The GSB has limited jurisdiction to deal with workplace disputes; they are not, for example, allowed to deal with classification disputes. This limitation, based on the particulars of the public service, should have no application to the workers in CCACs.
- ONA is committed to a process whereby the parties are involved in choosing an arbitrator to respond to particular issues; ONA is not prepared to lose this right.
- The GSB has, from time to time, a very large backlog of grievances coming out of corrections and the government services. Currently the parties to CCAC Collective Agreements have the ability to address the priority and timing of the resolution of disputes. Failing agreement, the LRA provides an expedited process. ONA is not prepared to give up these rights for its members and add their disputes to the long queue at the GSB.
- Most GSB hearings are held at the board's offices in downtown Toronto. With the current dispute with arbitrators regarding payment, ONA understands that the panel of arbitrators who are still prepared to hear cases are not prepared to travel. ONA's CCAC members are spread all over the province. Currently they are entitled to have their arbitrations heard near their workplaces. ONA does not want this to change.
- ONA is aware of the ongoing issues confronting the administration of the GSB and does not wish to, or need to get involved in those issues, for example, the appointment and payment of arbitrators, the scheduling of hearings, the costs, and the backlog.
- The GSB is administered jointly by the government and the unions representing the effected employees. If the CCAC workers were added to the jurisdiction of the GSB it would put an additional number of unions at the table. Not only would this needlessly complicate the discussions and decision making, it would add administrative burden and cost to ONA that it does not wish to assume.
- Furthermore, given that there are only approximately 7,000 LHINs employees who would be included in the jurisdiction of the GSB, which otherwise covers approximately 70,000 workers, neither the CCAC members nor their unions would have the proportional weight to give their members any meaningful voice at the table.

There is no justification for removing this small group of health care workers from the grievance resolution process to which they are accustomed, and is applicable to all other health care unions, and sticking them into the flawed processes of the GSB.

Pay Equity Act

The *Pay Equity Act* deems Crown agencies to be part of the Crown. Accordingly, if the CCACs are moved to the LHINs without a change in designation as Crown agencies, the LHINs would have to do a job-to-job comparison plan with other Crown employees; the parties would have to renegotiate its current proxy plans.

CONCLUSION

ONA generally supports the transition of home care services from CCACs to LHINs, ensuring the stability of home care services. However, we have raised some very serious concerns regarding the fragmented approach to care for patients and their families under the existing model of CCACs.

We believe the way forward in the transition to LHINs is to expand the current care coordination practice to coordinate the full care needs for the patient. Ultimately, we believe this requires the integration of direct home care delivery with care coordination in a fully public home care system. We already have the current precedent for direct care roles – such as Rapid Response Nurses – which show positive value for patient care.

The greatest challenge in the transition to LHINs will be avoiding the fragmented and uncoordinated approach to home care services in the current CCAC model of home care services provided by multiple service providers, which the Discussion Paper proposes will continue.

We also have some very real concerns about the impact on our members of the transfer of employment and responsibility from the CCAC to the LHINs. These concerns must be taken into account and appropriate solutions reached. While we understand that the Government wants to put "Patients First," workers who provide health care services for those same patients must have their concerns respected.

We thank you for the opportunity to provide our input on the Discussion Paper and we look forward to further consultation as the proposed structural changes are more concretely defined.

¹Auditor-General of Ontario, 2015 Annual Report at page 70.

²Williams, A.P. et al. "Reducing Institutional and Community-Based Care," *Healthcare Quarterly* 12(2): 2009.