RNAO Submission to CCAC Procurement Review

The Registered Nurses' Association of Ontario (RNAO)

438 University Avenue, Suite 1600, Toronto, Ontario, M5G 2K8
phone: 416-599-1925 toll free: 1-800-268-7199 fax: 416-599-1926
www.rnao.org

Table of Contents

SUMMARY OF RECOMMENDATIONS

Recommendation 1

We recommend the government provide adequate, multi-year funding to facilitate the health care transformation agenda, including transition costs, and provision of increased high-quality home care services.

Recommendation 2

We recommend the government discontinue use of the competitive bidding process and adopt another method of allocating services and ensuring value for money in the provision of home care that is less expensive and inefficient.

However, if competitive bidding is maintained the review should recommend that:

Recommendation 3

We recommend not-for-profit providers have the right of first refusal on all new contracts for home care. A two-stage process should be introduced:

1. In the first stage, only not-for-profit providers would compete. Contracts would be allocated only among not-for-profit providers.
2. If there were no not-for-profit providers competing, or if they did not meet thresholds for their scores, the RFP process would be opened up to for-profit providers.

Recommendation 4

We recommend the RFP scoring system recognize the role and value of community based not-for-profit agencies, including the indirect benefits such as volunteer services.

Recommendation 5

We recommend the initial contract period be extended to five years with the possibility of renewal for an additional five years based on good performance.

Recommendation 6

We recommend all CCACs be required to meet provincial standards throughout the RFP process. Standards should include: mandatory site visits; mandatory debriefing; and, mandatory public access to successful bids.

Recommendation 7
We recommend measures be put in place to ensure that bids priced 15 per cent below the average price for a given RFP be dropped.

Recommendation 8
We recommend prohibiting elect-to-work employment relationships for suppliers of home health care services and providing incentives for employment models that foster continuity of care and continuity of caregiver.

Recommendation 9
We recommend providing greater weight in scoring to the principles of continuity of care and continuity of care giver. To this end, the quality component of the RFP score should evaluate human resource management issues, which should make up a substantive share of the total score, and include the following benchmarks:

- percentage of full-time employment;
- length of orientation;
- spending on ongoing education and professional development;
- rates of absenteeism;
- turnover rates;
- overtime rates; and,
- remuneration, including pensions and benefits.

Recommendation 10

We recommend that contract administration remain with CCAC's and case management be performed by an RN from the provider organization in a care coordinator role.

Recommendation 11

We recommend an external process for yearly client and staff satisfaction surveys be created and, a complaint process for clients and staff be established, both at arm's length.

1. Introduction

We welcome this opportunity to participate in the review of the competitive bidding process and to convey the views and recommendations of Ontario's registered nurses. In announcing the review, the Minister stated:

> It is important for people receiving home care services to know they are getting the highest quality services possible. There are significant concerns that the scale of contract changeovers is causing instability in the home-care labour force and in the homes of patients. This review will look at how the process is working for patients and how it can be improved to ensure a consistently high level of care.

We believe these and other statements provide Ms Caplan with the opportunity to use a broad approach to reviewing how to secure quality of care, restore a vibrant workforce, and ensure value for money in home-care services.

In this brief, we provide an overview of home health care nursing practice, describe the impact of competitive bidding on home care, including increased for-profit delivery and financial and other costs associated with contract turnover, and outline the impact of competitive bidding on human resources issues. We argue that competitive bidding is an ineffective method of allocating health care services, and urge the review to recommend moving to another method of allocating these services. However, should Ms Caplan recommend that the competitive bidding process continue, we have made a number of recommendations that will shift its focus away from price and toward quality and continuity of care and caregivers.

2. Overview of home health nursing practice[1]

The focus of home health nursing is the care of individuals and their families throughout the community in settings that include traditional homes, group residences, school classrooms, shelters, and the street. Home health nurses are those for whom the scope of practice, in conjunction with the ability to practice holistic nursing in the context of a rewarding nurse-client therapeutic relationship, represents a highly fulfilling practice environment. Home health nursing has traditionally been considered a generalist practice, with the expectation that the nurse demonstrates competence and flexibility in caring for clients across the age and illness continuum.

[1] Community Health Nurses' Initiative Group, (2004). *Understanding Home Health Nursing: A Discussion Paper*.

Registered nurses (RNs) working in home health provide the full spectrum of care, combining critical thinking, comprehensive assessment, and clinical decision-making with expertise in the nursing management of intravenous infusion therapy (often via central venous lines), complex dialysis regimes, medication delivery via ambulatory pumps, and ventilator-dependent clients. Adding to the complexity of home health practice is the challenge of maintaining competence with the above clinical care knowledge and skills when they may be required sporadically.

In recent years, new opportunities have arisen for RNs working in home health to combine their generalist practice with the application of specialized knowledge and skills in such areas as home chemotherapy, enterostomal therapy, mental health, continence management, lactation consultation, palliative care and care of children with long-term health needs and their families.

Central to home health nursing is the nurse's understanding that s/he is the "guest in the house"[2], and the "stranger in the family"[3], with the resultant willingness and ability to work in collaboration with the client and adapt to an endless variety of client-controlled environments. The practice involves the knowledge and use of a vast array of technology, the need to cope with the full spectrum of traffic and weather conditions, fulfill reporting requirements, and implement strategies to overcome isolation from peers.

Acting as the health care team's eyes and ears, the home health RN plays a key role in coordinating care and communicating the status and needs of the client to the members of the health-care team. Expert home health nurses readily describe their sense of privilege and fulfillment in working in a holistic and committed therapeutic relationship with their clients. Their commitment to their chosen practice focus arises from a type of nursing that "takes the nurse to where the person lives in more than the literal sense...[and gives them] the opportunity to come to know the person and family as they really live and to become a meaningful presence actively promoting health and quality of life in family and community patterns of daily living."[4]

---

[2] Bramadat, I.J., Chalmers, K., & Andrusyszyn, M.A. (1996). Knowledge, skills and experience for community health nursing practice: the perceptions of community nurses, administrators and educators. *Journal of Advanced Nursing, 24*, 1224-1233.

[3] Coffman, S. (1997). Home care nurses as strangers in the family. *Western Journal of Nursing Research, 19* (1), 82-96.

[4] Clarke, P.N. & Cody, W.K. (1994). Nursing theory-based practice in the home and community: The crux of professional nursing education. *Advances in Nursing Science, 17* (2), 41-53.

3. Impact of competitive bidding on home care

> *The current competitive bidding process used by the Ontario CCACs to contract service providers was described at one of the initial training meetings as 'no different than tendering gravel'. Contracting nursing services is however profoundly different than contracting the delivery of gravel.*
>
> *RN, Eastern Ontario*

We understand that funding levels are beyond the scope of this review. However, the problems we are currently confronting in the home care system arise both from the competitive bidding process and from historic underfunding. We acknowledge the current government's actions in its first year in office to address these issues. However, from a funding perspective, improvements in the competitive bidding process will only address allocation of funds. Truly achieving the government's goals for the quality and role of home care in the future will require sufficient levels of funding, as well as major changes in the reform of the allocation process.

Recommendation 1

We recommend the government provide adequate, multi-year funding to facilitate the health care transformation agenda, including transition costs, and provision of increased high-quality home care services.

Ontario's experiment with competitive bidding in home care has been a failure. It has resulted in the following: a large shift to for-profit providers; a loss of the social infrastructure associated with not-for-profit providers; a loss of community nursing staff; grave concerns about the quality of care; a misallocation of resources resulting from the high transaction costs associated with the RFP process; and, tensions between the direct providers and CCACs.

The competitive bidding process, by its nature, can measure price much more effectively than it can measure quality. Since competitive bidding was initiated in 1996, there have been attempts to improve both the process and the measurement of quality. The latest was the standardized RFP template that was introduced in 2004.

In a recent article, University of Toronto Professor of Health Policy Raisa Deber catalogued these problems associated with competitive bidding in the health-care sector:[5] our limited ability to fairly price and cost health-care services and

[5] Deber Raisa (2004), "Cats and Categories: Public and Private in Canadian Health Care," *HealthcarePapers*, Vol. 4 (4), 51-60.

different levels of complexity in these services; the expensive nature of systems required to capture and audit information; and, low measurability of health-care services which impedes effective performance monitoring. (Deber uses a visit to a family physician to demonstrate the difficulties in measurability; we believe a home health-care nurse visit is an equally relevant example.)

Other authors elaborate on the complexities of measuring health-care services and, in a review of the literature, go so far as to say that "measurability in home care is in its infancy:"[6]

> To develop sound measures that allow their precise measurement, the processes and outcomes involved in home care need careful definition. Attempts to reach conceptual clarity about the dimensions of continuity of care have resulted in a range of definitions and terms to describe continuity in different service delivery contexts and from different professional and patient perspectives. Central to these are the elements of consistency (in provider and/or service), progression towards defined outcome of care; coordinated information transfer and on-going relationships.[7]

For competitive bidding to be effective, you must be able to measure not only the services themselves, but also their quality. Yet we cannot effectively quantify these services, nor their quality. Price, on the other hand, is easily quantified, and that leads inevitably to a competitive bidding process biased toward awarding on price rather than quality. This makes the RFP process an expensive, inefficient way of attempting to ensure quality services and value-for-money in home care services.

> Recommendation 2
>
> We recommend the government discontinue use of the competitive bidding process and adopt another method of allocating services and ensuring value for money in the provision of home care that is less expensive and inefficient.

If, however, Ms Caplan recommends the competitive bidding process be maintained, we outline through the remainder of this document recommendations that would strengthen the process.

---

[6] Abelson Julia, Hutchison Brian, O'Connor Denise, Tedford Gold Sara , Woodward Christel (2004), "Managing under managed community care: the experiences of clients, providers and managers in Ontario's competitive home care sector," *Health Policy*, Vol. 68 (3), 359-372, p.360.

[7] Ibid.

3.1 Not-for-profit delivery

> *I remember clearly the day I decided to leave community visiting nursing. I started at 8:00 am and as the day went on was paged to add more and more clients. I worked 12 hours, drove 190 km, and saw 20 clients. The last client was a new admission, a cancer client, just discharged from the hospital. He was clearly frightened with tubes draining body fluids from his abdomen and in pain. I felt that I had very little energy left and had nothing left in me to give to this man…. I did my best to comfort and alleviate his fear and pain and promised I would return first thing in the morning. I never felt so helpless and frustrated. I did not go into nursing to provide care like that and was even thinking about leaving the profession that had become such a part of who I am. I could not provide the same quality of care working for the for-profit agency as I did for VON. I was the same nurse with the same education, same caring attitude, and same experience; however the for-profit agency's policies do not encourage quality care delivery*.
>
> *RN, Southeastern Ontario*

In their day-to-day working lives, RNs have no difficulty in differentiating between the quality of care offered by for-profit and not-for-profit providers. These differences include; depth of orientation; levels of training required to perform complex and potentially life-threatening procedures; depth of clinical support and supervision; and, workload issues that have an impact on patient care and patient safety.

The competitive bidding process has resulted in a large shift in the provision of home care services to the for-profit sector. The share of the total volume of nursing services awarded to for-profit providers increased from 18 per cent in 1995 to an estimated 46 per cent in 2001.[8]

One aspect of the quality of service not captured in any individual RFP is the long-term synergies associated with not-for-profit providers of home care. These include: fundraising capabilities, volunteerism, and integration with other services in the community. These synergies increase quality and quantity of care for any given level of government investment. The cumulative impact of awarding individual RFPs has been the loss of not-for-profit providers in some areas of the province. Loss of these providers is distinct from the loss of for-profit providers. For-profit providers have fewer barriers to re-entering the home care market. In addition, the loss of not-for-profit providers results in losses of social infrastructure that are not associated with the loss of for-profit providers.

[8] Doran, Diane, Picard, J. (2004), *Community Nursing Services Study, Phase 1 Report*.

The evidence shows that health care provided on a not-for-profit basis results in better quality of care. Dr. PJ Devereux's meta-analyses showed lower incidence of mortality for both in-patients and out-patients in not-for-profit hospitals [9] and haemodialysis units[10] . A further Devereux study concluded that for-profit hospitals charge significantly more than not-for-profit hospitals (19 per cent).[11]

Professor Deber succinctly summarizes the benefits of not-for-profit delivery:

> As Romanow recognized, many but not all healthcare services are complex and difficult to measure. The literature suggests that not-for-profit delivery tends to be superior under such circumstances, precisely because not-for-profit providers are less sensitive to bottom line incentives, and hence are more likely to deliver the desired level of quality in such complex environments even when this is not specifically required by the contract.[12]

Similar conclusions can be found on the question of costs associated with for-profit delivery:

> …it must be recognized that the incentives inherent in a corporate structure, all other things being equal, appear inimical to many desired outcomes of a healthcare system. For profit firms have an incentive to maximize the amount they bill payers (thus increasing total healthcare spending and the burden on payroll), minimize the quality of care (unless this will harm their business) minimize labour costs and minimize spending on non-profitably activities (including particular services, client groups and activities such as teaching, research and community service). These tendencies can be controlled only through fairly elaborate measurement and monitoring of performance which carry their own costs and which smaller providers may be unable to meet.[13]

---

[9] Devereaux PJ, Choi PT, Lacchetti C, Weaber B, Schunemann HJ, Haines T, et al. (2002), "A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals," *Canadian Medical Association Journal*, Vol. 166 (11), 1399-1406.

[10] Devereaux PJ, Schunemann, HJ, Ravindran N, Bhandari M, Garg AX, Choi PT, et al. (2002), "Comparison of mortality between private for-profit and private not-for-profit haemodialysis centres: a systematic review and meta-analysis," *Journal of the American Medical Association*, Vol. 288 (19), 2449-57.

[11] Devereaux, PJ, Heels-Andell D, Lacchetti C, Haines T, Burns KEA, Cook DJ, et al. (2004), "Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis," *Canadian Medical Association Journal*, Vol. 170 (12), 1817-24.

[12] Deber, p.58.

[13] Ibid, p.59.

While we understand that some believe the government is precluded from directing public funding for home-care services to not-for-profit providers, a recent opinion outlined there is no such constraint under either domestic or international law.[14]

Recommendation 3

We recommend not-for-profit providers have the right of first refusal on all new contracts for home care. A two-stage process should be introduced:

1. In the first stage, only not-for-profit providers would compete. Contracts would be allocated only among not-for-profit providers.
2. If there were no not-for-profit providers competing, or if they did not meet thresholds for their scores, the RFP process would be opened up to for-profit providers.

Recommendation 4

We recommend the RFP scoring system recognize the role and value of community based not-for-profit agencies, including the indirect benefits such as volunteer services.

3.2 Costs of contract turnover

> *In most cases, it didn't matter if the person was palliative or just receiving a dressing for a few days, their nurses changed with the process. The people and their families who were "dependent" on these nurses had to start over bringing the new nurses up to speed. This takes a great amount of energy at a time when energy is often at its lowest, for both the person and the family. Some information is documented in the charts. But as we know, so much is remembered in the providers' heads. This can include: what is the most painless way to do the procedure, the best timing for procedure, best distractive techniques to increase comfort, communication, religious considerations etc.*
>
> *RN, Central Ontario*

The impact of contract turnovers on patient care and caregivers has been widely described as one of the major problems associated with the competitive bidding process. We estimate that each year in Ontario more than 1,100 clients in the home-care system are required to change providers as a result of the RFP process.

RNs are deeply concerned about the impact of contract turnovers on patient care and the efficiency of the home care system. The direct nursing impacts of the loss of continuity of care range from psychological or physical discomfort to set backs in the healing process with grave implications. The impacts differ by type

[14] Letter to Hon Elinor Caplan, CCAC Procurement Project from Steven Shrybman, Sack, Goldblatt Mitchell, Barristers and Solicitors, January 14, 2005.

of client. The effects can be particularly devastating on elderly people and children with chronic care needs and their families. The confusion, loss of continuity, and breaks in care that result at contract turnovers can send these already fragile families into crises. Crises that can result in loss of independence and admittance to long term care facilities. RNs find changes in providers inevitably result in duplication of services, and therefore result in an inefficient use of scarce health care resources. The instability associated with frequent contract turnovers has made recruitment and retention in this sector extraordinarily difficult (This issue is addressed in the following section).

As noted in the literature, there are high transaction costs associated with competitive bidding for home health care. These include: costs to providers and CCACs of preparing and evaluating bids; costs associated with measuring and tracking quality for the RFP process; the communication, consultation and replication of services costs when there is a change in providers as a result of an RFP. One might assume that costs associated with efforts at measuring quality are worthwhile. The efforts to measure quality for RFP purposes, however, might not directly coincide with those required to improve quality.

Because of the difficulties associated with measurement outlined above, attempts to accurately capture quality in the RFP process often do not meet with success. This has been illustrated by the ongoing attempts to reform the process since its introduction.

An example of such limited success is the current scoring process. Changes to the RFP process have been made to attempt to address the difficulties in measuring quality. One of these has been the requirement that all bids pass a quality threshold set by individual CCACs before the price envelope is opened. Quality now uniformly comprises 75 per cent of the score; while price comprises 25 per cent.

As a result of these weights, a lower-quality bid would be awarded a contract only if the difference between the price scores was more than 36 per cent. Table 1 below shows the cross-over point at which the scores of a higher and lower quality bid would be equal. Any greater difference in quality or less difference in price results in the higher quality bid being awarded the contract. The fact that lower price bids continue to win contracts is an indicator of both the intensity of the pricing competition, and the lack of transparency in how price scores are awarded.

Table 1	*Quality Score*	*Price Score*	*Total Score*
Lower quality/lower price	72	25	60.25
Higher quality/higher price	75	16	60.25
Percentage difference	4%	-36%	

The costs and negative impacts associated with the RFP process increase with the frequency of contract turnovers. The costs also increase with variations in the processes among CCACs. Furthermore, the greater the consistency among CCACs the greater the transparency and lower the opportunity for arbitrary decision making that might not be in the best interests of clients. To mitigate all of these impacts, we make the following recommendations.

Recommendation 5
We recommend the initial contract period should be extended to five years with the possibility of renewal for an additional five years based on good performance.

Recommendation 6
We recommend all CCACs be required to meet provincial standards throughout the RFP process. Standards should include: mandatory site visits; mandatory debriefing; and, mandatory public access to successful bids.

Recommendation 7
We recommend measures be put in place to ensure that bids priced 15 per cent below the average price for a given RFP be dropped.

4. Impact of Competitive Bidding on Home Health Care Nursing Workforce

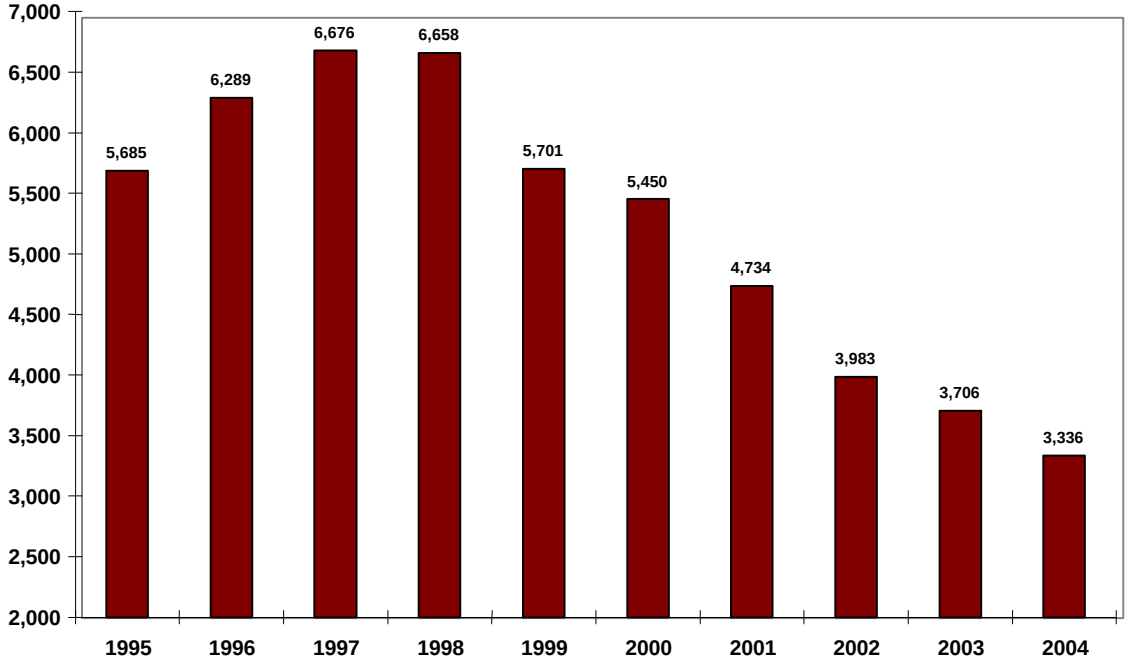
> *The turnover is amazing. When limitations are removed, we are overwhelmed and the search begins for new staff. New nurses are hired and orientated but realize quickly that the time spent is not equal to remuneration and quickly look at other job opportunities. We have lost many seasoned, caring nurses to the hospitals. Frustration was part of the reason for their leaving but also a need to look ahead to retirement and more financial security for retirement.*
>
> *RN, Northern Ontario*

RNs are leaving the sector because of the employment instability which results from contract turnovers. This instability, in combination with the low remuneration in the sector, results in many nurses working both in home care and in other sectors. They need to do this to make ends meet, and in case they lose their jobs because of contract turnover.

The College of Nurses of Ontario (CNO) provides data on the number of nurses working for home health care/visiting nurse agencies. Since the introduction of the competitive bidding process, these data show a precipitous drop in the number of RNs working for these agencies. While the data show the number of

nurses working in home health care peaked at 6,676 in 1997, for the latest year the data show only 3,376 RNs working in home health care. While we recognize this is likely an overestimate of the drop in nurses in the sector, it illustrates two trends. First, nurses are voting with their feet to leave home health care. Second, given that a large number of multiple job holders is likely contributing to the drop in reported RNs in this sector, it confirms that home health-care nurses must work multiple jobs to make ends meet.[15] The data also show a sharp rise in the average age of RNs who are reporting that they work for visiting nursing agencies; from 42.8 in 1997 to 46.4 in 2004. [16] The share of nurses who are under 30 working for visiting nursing agencies has also dropped; from 13.3 per cent in 1997 to 6 per cent in 2004.

Chart 1: RNs reported as working in Home Care Agencies



[15] CNO employment data does not report multiple job holders. If a member states they are working for multiple employers, the sector is determined during the data cleaning and editing processes: the employer information is validated against other information, such as their position in nursing and primary area of practice.In some cases, when a member informs to be working for multiple employers, and in multiple positions in nursing and primary areas of practice, the case is deemed "not specified". This number is very small (around 2% of cases).

[16] Special tabulation, College of Nurses of Ontario.

We have grave concerns about the elect to work employment relationship of some for-profit providers and RNs. This employment arrangement contradicts any focus on patient centered care which invariably requires continuity of care and continuity of care giver and undermines the capacity to provide effective care. Moreover, elect-to-work allows nurses to "skim" the patients they prefer. Indeed, in this employment relationship, RNs could determine not only what hours they would work, but which patients they care for. Many times, this results in patients with complex psychosocial needs having many different caregivers –a factor that only increases the client's burden.

Additionally, the elect to work relationship, in combination with a competitive model of home-care delivery that emphasizes cost controls, results in a disincentive for RNs to care for complex and difficult patients who require extra time and effort. The nursing community vehemently opposes further casualization or increasing the over-reliance on part-time employment. Quality and safe patient care requires a substantive proportion of RNs working full-time (at least 70%).

Elect to work employment also allows the employer to avoid the *Employment Standards Act* paid public holidays and termination and notice pay provisions that apply to other employment relationships.[17]

The Canadian Home Care Human Resources Study provides further evidence of the negative impact of competitive bidding on the home care nursing workforce. It shows clearly that home-care nurses working under managed competition experience both the worst working conditions and lowest morale of every delivery model for home care (managed competition is referred to as the contractual model in the study).

As Table 3 shows, when compared to all other models, the contractual model in Ontario provides for the worst working conditions for RNs, including the lowest wage rates. Only 32 per cent of RNs in the contractual model are satisfied with their level of pay — 15 percentage points below the mean across delivery models. The contractual model also has the lowest percentage of nurses paid for overtime and for employer-cancelled shifts, and the highest number of unpaid hours in an average week. Table 4 shows the contractual model has the lowest job satisfaction for RNs across delivery models, and that almost one quarter of the nursing workforce intends to leave over the next 12 months.

[17] Employment Standards Fact Sheet –How are you covered by the ESA http://www.gov.on.ca/LAB/english/es/factsheets/fs_covered.html

This review process, and the government's health care transformation agenda itself, will not be successful without addressing the human resources issues resulting from competitive bidding. The correlation between working conditions and nurse satisfaction are very clear. We also know that nurse satisfaction and patient outcomes are correlated.[18,19,20,21]

Recruiting and retaining quality staff requires a quality work environment. This includes: job security; a remuneration package that reflects a fair wage and includes pensions, benefits, training and broader professional development opportunities; and employers in the sector who provide research and leadership opportunities.

[18] Aiken Linda H., Clarke Sean P. (2003), "Registered Nurse Staffing and Patient and Nurse Outcomes in Hospitals," Policy, Politics, and Nursing Practice, Vol. 4 (2), 104-111.

[19] Aiken Linda H., Clarke Sean P., Rocket Joan L., Sloane Douglas M. (2002), "Organizational Climate, Staffing, and Safety Equipment as Predictors of Needlestick Injuries and Near-Misses in Hospital Nurses," *American Journal of Infection Control*, Vol. 30 (4), 207-216.

[20] Aiken Linda H., Clarke Sean P., Silber Jeffrey H., Sloane Douglas M., Sochalski Julie (2002), "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction," *Journal of the American Medical Association*" Vol. 288 (16), 1987-1993.

[21] Aiken Linda H., Clarke Sean P., Sloane Douglas M., Vahey Doris C., Vargas Delfino (2004), "Nurse Burnout and Patient Satisfaction," *Medical Care*, Vol. 42 (2), Suppl: II-57-II-66.

Table 2: Working Conditions by Delivery Model					
	Public Provider	*Public Prof & Private Home Support*	*Mixed Public-Private Model*	*Contractual*	*Overall*
Mean Hourly Wage*	$25.07	$26.33	$26.38	$22.37	$24.00
"Satisfied/Very Satisfied" w/Pay (%)*	61	59	68	32	47
Paid Overtime (%)**	70	70	74	62	66
Paid for ER Cancelled Shifts (%)***	33	16	33	9	18
Unpaid Hours in Average Week*	2.3	2.2	2	4.4	3.5
* Statistically significant difference between delivery models (p<.001; ANOVA) ** Statistically significant difference (p<.05; chi-square statistic) *** Statistically significant difference between work status proportions (p<.05; chi-square statistic)					
Source: The Home Care Sector Study Corporation (December 2003). Canadian Home Care Human Resources Study. http://www.homecarestudy.ca. http://www.cacc-acssc.com/english/newsroom/links.cfm.					

Table 3: Job Satisfaction by Delivery Model						
	Public Provider	*Public Prof & Private Home Support*	*Mixed Public-Private Model*	*Contractual*	*Overall*	
"Satisfied/Very Satisfied" w/Job (%) *	84	84	84	72	78	
Intending to Leave Employer w/in 12 Mo.s (%) *	6	15	10	23	17	
	Wage is too low	*Poor job security*	*Not sufficient benefits*	*Job is too stressful*	*Want to change work status*	*Working conditions not good*
Reasons for Wanting to Leave Employer (%)	64	54	46	43	39	30
* Statistically significant difference (p<.001; chi-square statistic)						
Source: The Home Care Sector Study Corporation (December 2003). Canadian Home Care Human Resources Study. http://www.homecarestudy.ca. http://www.cacc-acssc.com/english/newsroom/links.cfm.						

Recommendation 8
We recommend prohibiting elect-to-work employment relationships for suppliers of home health care services and providing incentives for employment models that foster continuity of care and continuity of caregiver.

Recommendation 9
We recommend providing greater weight in scoring to the principles of continuity of care and continuity of care giver. To this end, the quality component of the RFP score should evaluate human resources management issues, which should make up a substantive share of the total score, and include the following benchmarks:

- percentage of full-time employment;
- length of orientation;
- spending on ongoing education and professional development;
- rates of absenteeism;
- turnover rates;
- overtime rates; and
- remuneration, including pensions and benefits.

2.1 Duplication of Services

There is duplication of services between case managers and point-of-care nurses. This duplication has both direct and indirect costs. Some of these costs arise from the unnecessary tension and dissatisfaction of point of care nurses.

Home health-care providers have outlined the difficulties in competing for RNs against CCACs who can provide hours, job security and wages beyond what they can compete with. The table below shows the increase in RNs working for CCACs. While the number of RNs working in CCACs has dropped from its peak of 2,576 in 2002 to 2,259 in 2004; it remains well above the level in 1999 when these data were first collected; and the drop in nurses working in visiting nurse agencies is far more pronounced (see Chart 1).

Table 4: RNs working in CCACs

	1999	2000	2001	2002	2003	2004
RNs working in CCACs	1,633	2,231	2,336	2,576	2,493	2,259
Source: CNO special run						

From the perspective of efficiency and recruitment and retention, the case management functions should be transferred to point-of-care RNs while contract management and administration may remain with the agencies responsible.

This can be accomplished by piloting case based rather than visit based funding. The goal would be to move to outcome-based funding and allow the care providers to decide on the number of visits and processes to achieve the target outcomes. It would allow providers to be more innovative in their delivery of service. It would be most appropriately piloted for resource-intensive care, such as wound and palliative care.

Recommendation 10

We recommend that contract administration remain with CCAC's; and case management be performed by an RN from the provider organization in a care coordinator role.

5. External Checks and Balances

Even with full implementation of recommendations 3 through 10, the inherent flaws in the competitive bidding process will remain. To overcome the potential impacts of these flaws, external mechanisms are necessary to monitor performance and enable an external appeals process. While additional processes may be put in place with a view to overcoming these flaws, it must be acknowledged that such processes will add to the cost of home health care and divert resources from care provision.

Recommendation 11

We recommend an external process for yearly client and staff satisfaction surveys be created, and a complaint process for clients and staff be established, both at arm's length.

6. Conclusion

We appreciate the opportunity to participate in the review of the competitive bidding process. We believe that changes to the home health care system that will increase continuity of care and care giver, foster excellence in care and facilitate retention and recruitment are possible. Furthermore, we believe these changes are essential to the effective implementation of the government's transformation agenda.