

An Analysis of the Impact of the New RFP for Visiting Nursing in Hamilton

Prepared for the Hamilton Coalition for Quality Home Care
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1. Introduction

The following analysis supports the conclusion that the Request for Proposal (RFP) process as it unfolded in 2007 in the Hamilton Niagara Halton Brant (HNHB) CCAC is fundamentally flawed, that the results should be overturned and the process suspended until it is fixed. It begins with the Caplan Report, speaks to some specific features of the RFP template and evaluation process and concludes with a description of what this result will likely mean to Hamilton.

2. Realizing the Potential for Home Care: Competing for Excellence by Rewarding Results (2005) –The Caplan Report

Commissioner Elinor Caplan provided a very comprehensive examination of Home Care in Ontario and the government's¹ response was admirable in that it embraced most of the recommendations and offered good reasons as to why it rejected a few. While it would be best if all the government's commitments had been implemented before an RFP was issued, the following two likely would have been instrumental in avoiding the current situation.

Commitment 1.1.1

Establishing a Centre for Quality and Research in Home Care to lead the necessary reform to inform policy... and report on client outcomes, establish benchmarks, disseminate best practices, encourage innovation and promote excellence in home care.

Comment

This has not happened. The science of identifying client outcomes for home care remains in its infancy. It remains up to each agency to identify best practices and be innovative. As there is no centralized, research-based repository of data standardizing quality measurement each agency must develop these. Only large organizations with their own research capacity can dedicate resources to developing the clinical outcome measures asked in this RFP. In my doctoral research² I found that the nature of the competitive process means that many agencies hold best practices and innovations as proprietary knowledge and do not share these across the sector so we see piecemeal improvement that privileges large organizations in the competitive process. Through my recent work I have found that this situation has not changed. There are few commonly agreed standards on outcome measurements in this sector as emerging knowledge is not shared or being published in peer-reviewed journals unless it is conducted by university researchers. **This means the central claim that the RFP can reliably evaluate whether agencies are providing quality care is problematic given the way in which this RFP focused on quality and agencies' plans to measure clinical outcomes and did not systemically evaluate agencies' past experience.**

¹ These commitments are taken from Ontario government document "Choosing Quality, Rewarding Excellence: Ontario's Response to the Caplan Report on Home Care", May 1, 2006.

² O'Connor, Denise (2005) Governing Home Care in Ontario and England: Markets, Contracts and the Effects on Service Providers and Workers. McMaster (PhD thesis).

Implications

There are no consistent, objective standards for measuring quality in home care against which the agencies' plans for quality and outcome measurements can be judged. "Quality" remains subjective. Thus, the RFP evaluators are *not* comparing apples with apples and their evaluation of quality is not based on scientific evidence because little is published. This means the claims that this process is fair, transparent and objective are false.

Commitment 1.2.5

Creating incentives for excellence by establishing a Preferred Provider designation for agencies with good employment practices and demonstrated excellence in service to clients.

Comment

This designation will begin in the next contract period despite CCACs having ten years of experience from which to draw to evaluate current providers. The current RFP template does not ask whether agencies meet employment standards. As it stands, demonstrated excellence in service to clients is *not* a factor into the evaluation process (see below for details). This should be a pre-condition before any bid is accepted.

Implications

It appears this recommendation was designed to ensure that good agencies are not sideswiped by flawed RFPs. If experience and good employment practices counted, and had there been the opportunity to designate Preferred Providers based on this, we may not have been in this situation now.

3. The Current RFP

Why an RFP now?

The province has chosen to proceed with the RFP process despite the fact that Elinor Caplan urged that her recommendations be implemented before the process was reintroduced across the province. The HNHB CCAC is the first to use the new template.

The New RFP Template

As this is the first time the new RFP template and evaluation criteria were used provincially, it was up to the individual agencies to guess what the criteria and framework for responses the CCAC required. The questions were very future-oriented, asking about "plans" for measuring clinical outcomes, among other things. As stated in Section 2, there is little in the way of evidence-based standards from which to develop these measurements. We do not know what the evaluation criteria are; they are secret. This suggests that agencies are evaluated against a check-list, not holistically. In other words, the way in which the information is presented is more important than what agencies actually do in practice. There will be organizational learning from this experience transferred to those competing in the next community but **Hamilton is paying a heavy price for this lack of transparency with respect to the HNHB CCAC's expectations for the contents of the proposal and their piecemeal approach to evaluation.**

What we do know is that **an agency's past experience in delivering service still counts for very little in the evaluation process.** This remains an absurd feature of the contracting process as we know that past behaviour is the best predictor of future behaviour. There is no provision for input from, for example, case managers who have

direct experience with each agency. **One has to ask what possible public purpose is served when feedback that directly evaluates service is ignored yet phantom quality standards form the crux of the evaluation?** The former is *bone fide* feedback on the quality and effectiveness of agencies that remains an untapped source of rich information. It is more reliable than hypothetical plans and unvalidated quality and outcome measures. We hear that case managers are calling the losing agencies and crying because of the unfairness of this situation and their view that the future will be bleak without them.

4. The Effect on our Community

VON Hamilton and St. Joseph's Home Care (SJHC) currently hold 80% of visiting nursing in Hamilton and are well established non-profit agencies. Both have been home care leaders in this city, as well as the province and the country for decades. They ran the first home care pilot for the federal government in the 1960s. In fact, they created home care for this country. They have provided a model of collaborative, quality care over many decades³. They are each deeply integrated into the community through a variety of committees and organizations that span the continuum of health and social services. **These are both organizations that bridge the health–social services divide on the ground in a way that is crucial to the health of our poorest, marginalized citizens,** a particularly important consideration given that Hamilton has a disproportionate number of poor, marginalized people.

Both agencies provide “wraparound services”. VON, for example, provides Adult Day Program, Meals on Wheels, Volunteer in-home Hospice, Caregiver Support Education and Respite, Tele-Touch, Volunteer Visiting among others. SJHC has a Home Maintenance Program (where it serves as a broker between screened handymen and clients), funded directly by the MOHLTC as well as other services. Both VON and SJHC receive United Way dollars. These ancillary services all assist in keeping people healthy and at home. While nurses have a very specific role, many times they identify that a visit or a meal or someone to fix the toilet would make all the difference and they make the connection for them. Those with agency experience believe that nurses make more of these types of referrals than case managers who do not spend much time in the home. Nonprofits developed these programs with donated dollars in response to needs that the community identified and then apply for funding from various sources not usually available to for profits. **Not one of the agencies that has made it to the next round in this contract provides any wraparound services in Hamilton.** This means that the new agencies lack the knowledge of this community they need to make these connections for their clients. Not one of these agencies is rooted in this community. This perspective and local knowledge will be missing from future CCAC tables to the detriment of Hamilton. This will be an impediment to efforts at local integration of health and social services.

We do not yet know how destabilizing this contract withdrawal will be to VON and SJHC, nor what the full impact of the cost of downsizing such as severance payments will be. What we can anticipate is that their infrastructure will be reduced. This will affect their capacity to provide wraparound services, be responsive to emerging community need and remain embedded in the network of community health and social service providers. Effective volunteer programs require strong institutional support to keep them running

³ O'Connor 2005

and sustainable; we fear that these programs could be undermined as a result of this situation.

SJHC and VON are good employers that provide full time jobs and benefits and meet Employment Standards. It is unlikely that many of their nurses will move to the winning bidders when they have a myriad of options in the secure, better paying institutional sector. Recent research⁴ has shown that over 50% of workers leave community care when their agency loses a contract. There is no reason to believe that nurses will behave differently this time. The HNHB CCAC has told agencies that winners can subcontract from the losers without the CCAC's permission, presumably to avert this exodus. One has to ask though, if these agencies are not qualified to hold a contract, how can their nurses be good enough to subcontract? It is a bizarre situation and one that is extraordinarily disrespectful of individual nurses and the community nursing sector as a whole.

5. Conclusion

We face a critical juncture in this community with respect to our future ability to provide health care in the most cost-effective setting. While it is only a small piece of a large health care system, home care is inextricably linked to the hospital and institutional sectors. And home is where people want to be.

A concept that used to be a standard in public administration when it comes to evaluating efficiency is "Pareto optimality". This refers to a situation where no one should be better off if they leave others worse off than before. **The results this RFP template produces simply do not meet this standard.** Those worse off include clients who lose their existing provider; potential clients who will not receive care because of reduced community capacity; the hospital patients stuck in corridors and the community at large that will most likely experience. It remains to be seen whether anyone receiving health care in Hamilton will be better off.

This decision is beyond the control of our Local Health Integration Network and subject to a process that is deeply flawed and overly bureaucratic. If these agencies are destroyed, there is no going back. Nonprofit organizations, the caliber of VON and St. Joe's Home Care, and the volunteers they inspire to donate their time to service, make a substantial difference to the quality of life in our community. To tell them they can no longer provide home care services because of the results of a demonstrably flawed process is simply unconscionable and serves no good public purpose.

⁴ See Aronson, J., M. Denton, et al. (2004). "Market-Modelled Home Care in Ontario." Canadian Public Policy XXX(1): 111-125; and Shamian, J., B. Mildon et al. (2006) Of Systems and Side Effects: Mobility in Home Care Personnel. VON/ MOHLTC http://www.von.ca/resources_reports.html .