

Capacity Building Initiative

Central Community Support Services Network

Looking Ahead: Opportunities for Collaboration and Integration in the Community Support Sector

An effective long-term home and community support system can be part of the solution to ensure timely discharge from hospitals and divert emergency department visits. Given the operational challenges that Central LHIN community support service agencies face and the important focus on integration, it's clear that the status quo is not an option. The Risk Assessment Survey conducted by PricewaterhouseCoopers on behalf of the Central LHIN and reported in July 2008 indicated significant operational challenges across all agencies related to funding, staffing and service capacity. In addition, infrastructure and volunteer vacancies were identified as areas of risk that have an impact on service capacity. Capacity building is an important and timely focus for the community support sector. There is growing evidence to indicate that long term home care, home support services and integrated systems of care delivery will be the future direction of a sustainable health care system. We see a growing need to strengthen the sector in order to mobilize around opportunities and move forward on common issues. Already, there has been tremendous benefit from the early collaboration and co-ordination between smaller groups and larger organizations. Our strength will come from leadership development and knowledge sharing among organizations working in the community support sector.

At CBI, we will encourage and seek new approaches and new solutions to support our common goal: ***a successful and growing community support sector that effectively supports clients in the community within an integrated system of care.*** The recent findings from the Continuing Care Research Project (Hollander, April 2008) clearly points out the importance, and potential cost-effectiveness, of home care services and the critical role played by informal caregivers, home support workers and other non-professional care providers. Hollander's report reinforces, once again, the benefit of long term home care and home support services when appropriately targeted.

Operating at Two Strategy Levels

The Capacity Building Initiative is working at two levels of strategy between short- term tangible initiatives that contribute to service delivery capacity and excellence and, at the same time, establishing strategy that will have a long term impact on re-alignment of the sector. The initial focus of work has been on establishing service delivery excellence which will lay the foundation for integrated models of care in the future. What we choose to prioritize in Year 2 must support re-alignment of the sector in the long-term. We must also clearly demonstrate support for the system goals in the Central LHIN Integrated Health Service Plan: quality, efficiency, access, and co-ordination.

Central LHIN Aging at Home Strategy: Year 2 Priorities

It is important to align our plan with the priority areas that have been established for Year 2 of the Aging at Home Strategy so that we support agencies for successful implementation. The priority areas include:

- supportive housing
- support for caregivers of seniors with dementia
- supports for independent living – home maintenance, homemaking
- ethno-cultural sensitive day programs
- health promotion and prevention – strokes
- increasing community supports in rural areas

Aging at Home proposals that have been recommended for year 2 will be approved by the Central LHIN Board in January 2009.

Capacity Building Initiative: Year 2 Objectives

1. continuation of year 1 initiatives
2. develop initiatives that align with Central LHIN year 2 expansion priorities and key messages
3. create a new priority that will support system integration and demonstrate benefit to clients

In Canada, even hospitals agree that community care is the answer.

“An effective long-term home care system is the answer – only then will seniors discharged from hospitals and nursing homes be diverted from emergency departments”.

Tom Closson, President and CEO, Ontario Hospital Association, 2008
Atkinson Fellowship Series, Toronto Star, November 15, 2008,

What Can CBI Do For The Central LHIN?

We need the collective action and infrastructure to successfully impact the Central LHIN's Integrated Health Service Plan, Aging at Home Strategy and new Service Accountability Agreements. This initiative gives the community support sector an integrating force which supports the re-alignment of organizations to contribute to the system level goals in the Central LHIN's Integrated Health Services Plan.



The following chart illustrates how the Year 1 Initiatives support the system goals in the Central LHIN Integrated Health Services Plan.

Year 1 Initiatives (Carried Forward to Year 2)	Access & Co-ordination	Quality	Efficiency
Service delivery best practices development: Supportive Housing for Seniors, Caregiver Support, Meals on Wheels, Home Maintenance	•	•	•
RAI-CHA common assessment implementation	•	•	•
Common database implementation	•	•	•
MIS/OHRS support		•	•
Share point knowledge exchange site development		•	•
Health and Safety Training implementation		•	•
Community Worker Safety Training implementation		•	•
HR Strategy implementation	•	•	•

Looking Ahead

According to a recent paper titled, Designing and Creating “Second Curve” Health Care Systems, (Ball, Merry, Verlann-Cole), we are teetering on the brink of a “Second Curve” paradigm of development in the health care system – a more evolved set of system, organizational and process designs that are required to satisfy the increasing demands of funders, service providers and customers in the knowledge economy. This requires new ways of thinking and behaving which are not vested in past thinking and practices. The paper goes on to describe an emerging vision of assumptions and beliefs that can challenge us all (Appendix B). With these new assumptions and beliefs in hand, leaders are challenged to re-think how to redesign their core and support systems, structures and processes in order to achieve real system improvements. There is a shift in resources from more expensive hospital-based services to home care and community agencies.

In October 2008, the Central Community Support Services Network invited Marg MacAdam to present her recent paper titled, Frameworks of Integrated Care for the Elderly: A Systematic Review (CPRN Research Report, April 2008). In this paper, MacAdam notes that investments have to be made to realize the potential of integrated care. Some key features of successful models which are relevant to the future development of the Capacity Building Initiative include:

1. umbrella organization structures to:
 - guide integration of strategic, managerial and service delivery levels
 - encourage and support effective joint-collaborative working
 - ensure efficient operations;
 - and maintain an overall accountability for service, quality and cost outcomes
2. organized provider networks joined together by:
 - standardized procedures
 - service agreements
 - joint training
 - shared information systems
 - common ownership of resources to enhance access to services, provide seamless care and maintain quality

Decision tools, common assessment and care planning instruments and integrated data systems are commonly listed infrastructure supports for integrated care. The strategic priorities established in the first year of the Capacity Building Initiative have begun this important foundational work for the community support sector to become a strong contributor to an integrated system of care. At the same time, there are many new and distinct initiatives that have developed which demand additional resources from the community support sector including Balance of Care, Doorways to Care and Home At Last.

In year 2, it is proposed that the Capacity Building Initiative lead the development of an integrated community support sector strategy which addresses both the infrastructure and the service delivery model that is sustainable and ready for health system integration. It is critical that both governance and senior management be engaged in the development of this strategy.

Appendix A: Brainstorming List of Integration Initiatives

Priority	Year 1 Initiatives Carried Forward	Potential New Initiatives
Quality	<ul style="list-style-type: none"> • develop service delivery best practices for home maintenance, supportive housing for seniors, caregiver support, meals on wheels • RAI-CHA implementation – additional sites 	<ul style="list-style-type: none"> • establish sector-wide wellness framework and integrate strong prevention best practices for all services • develop evaluation plan for pre and post implementation of service delivery practices • Establish community of practice for staff positions conducting assessments • Re-evaluation of levels of practices established in Year 1 for transportation, homemaking and day programs • Presentation at conferences and workshops
Information Management	<ul style="list-style-type: none"> • common database implementation – additional sites • support for consistent MIS statistical reporting, analysis and benchmarking to ensure standardized interpretation of functional centres • development of sharepoint services expansion 	<ul style="list-style-type: none"> • pilot front-line technology • feasibility plan for IT shared services • collaboration and agency support for the Community Annual Planning Submission process
People	<ul style="list-style-type: none"> • health and safety training implementation • community worker training implementation • HR/VR Strategy Implementation <p>NOTE: There is a real concern that training is consistently under-funded across agencies and the train-the-trainer model has been less than effective due to limited training expertise.</p>	<p>To Be Discussed: The development of the HR/VR strategy is just beginning. It is anticipated that the strategy will include recommendations for shared service and centres of excellence (TBD) to address future workforce planning including:</p> <ul style="list-style-type: none"> • Seniors helping seniors and non-traditional volunteers • Creating employment opportunities, particularly PSW • Responsiveness to diversity • development of organizational HR best practices (verifying credentials, criminal background checks, succession plans, other areas?) • leadership development strategy • shared services training strategy (including implementation gaps for best practices)
Integration	<ul style="list-style-type: none"> • New priority area for consideration – development of a sector-wide integration strategy 	<ul style="list-style-type: none"> • develop a business plan to build a strong portfolio of not-for-profit service providers in Central LHIN • inventory of common policies and procedures in key risk areas • lead role to implement transportation workgroup recommendations • lead role to implement supportive housing workgroup recommendations • feasibility study to implement “Veterans Independence Program model” for homemaking service providers • evaluate service delivery costs and fee structures to recommend steps to improve equitable access in day programs and transportation • adopt Central LHIN mental health and addictions cultural competency project • Conduct a market analysis and develop a service delivery integration pilot • linkage with Doorways to Care , Balance of Care, Home At Last • alignment of balanced scorecards – sector and agency levels • adopt new OACCAC satisfaction experience survey process

Appendix B: Second Curve Assumptions and Beliefs

(Designing and Creating “Second Curve” Health Care Systems)

A S S U M P T I O N S & B E L I E F S	
FIRST CURVE – CURRENT REALITIES	SECOND CURVE – EMERGING VISION
Acute care is the “hub of the system”.	Primary health is the “hub of the system”.
The delivery system is designed to meet the needs of healthcare providers.	The delivery system is designed to be customer-driven – while incorporating the needs of all care-givers along the continuum.
The systems, structures and processes have evolved overtime and have been cobbled together with unaligned assumptions in each silo. Lack of alignment and perverse incentives produce chaos in the system.	Systems, structures and processes are aligned and intentionally designed to achieve the outcomes required. Organizational alignment produces synergy within organizations and across the delivery system.
System is fragmented. Patient fends for her or himself, moving from silo to silo.	System is seamless. Coordinates needs of complex patients, using case managers for those that are especially difficult.
Sickness-focused. Episodic/Individual.	Health status & outcomes-focused. Systemic/ Population-based.
The system is designed to provide care and services to individuals (a diabetic, for example),	The system is designed to meet the needs of defined populations (diabetics for example) while retaining responsiveness to individual needs.
Designed to facilitate freedom, independence and autonomy of professionals.	Designed to facilitate the best combination of independent and interdependent professionals.
Systems, structures and processes are designed to control and regulate the people working in the system.	Structures, systems and processes are designed to facilitate collaboration, co-ordination and teamwork.
Hierarchical, command & control systems/structures/processes/culture creates toxic work environments.	Systems, structures and processes are designed to achieve the right balance of empowerment and accountability. High staff satisfaction rates.
“Accountability” means blame. Blame causes cover-up. Constant cover-ups means we don’t address design flaws in our systems, structures and processes.	“Accountability for Outcomes” is clear for every manager and Medical Chief. “Learning from our best mistakes” means continuous improvement.
Systems, structures and processes are designed to find out “who is to blame?”	Systems, structures and processes are designed to provide the support people need to achieve the outcomes for which they are accountable.
Information is centralized and hierarchical. Physician is supreme source of knowledge and dictator of therapy.	Information is dispersed. All caregivers and patients have direct access. Physician is integrator and facilitator of choices.
Medical record is fragmented and idiosyncratic to a particular silo. Individual caregivers work off entirely unconnected, often contradictory scripts.	Medical record is electronic and instantly updated and available for all relevant caregivers, all caregivers read from precisely the same script.
Tight centralized control and influence over the delivery system by unaccountable public servants.	Assumption that people are competent when accountabilities are clear and the supports required are in place
Assumption that performance problems result from lazy, unmotivated and uncaring people that need to be carefully monitored and controlled.	Knowledge that poorly designed systems, structures and processes leave people feeling powerless and uncaring. 93% of time performance issues are system design issues.
Designed to encourage political behaviour/power games.	Designed to produce collaborative behaviour and teamwork.
Behaviours characterized by fear and anxiety. Little trust.	Behaviours characterized by creativity and innovation. Lots of trust – and a real sense of purpose.

ASSUMPTIONS & BELIEFS

FIRST CURVE – CURRENT REALITIES	SECOND CURVE – EMERGING VISION
The system requires compliance from people.	The system seeks commitment from people.
Goal is to maximize resources for your silo.	Goal is to allocate resources appropriately within the system.
Huge resources are consumed in reimbursing inefficient systems. 30% of all work is unnecessary rework.	Huge resources are freed up for innovation and quality improvement. People & resources are leveraged.
Traditional budgeting processes are political, inflexible, linear and absorb up to 30% of senior executive's time, and 20% of middle managers efforts.	Strategic budgeting allocates resources based on evidence to achieve the outcomes and targets set by management and approved by the Board. Management time on the budget process cut by 50%.
Resources are allocated centrally based on politics in silos.	Evidence-based allocation of resources. Strategic budgeting.
Assumption: "First, do no harm." Provider intentions impeccable.	Assumption: Humans are inherently fallible. Harm occurs despite providers' best intentions.
Reality: Human error generates harm with threat of punishment as a deterrent.	Reality: System accepts human error as inevitable. Designs error proofing.
Mistakes are inevitable, but to be avoided; move on quickly if they occur. These are "undiscussables".	Mistakes are our most valuable source of learning. Learning from our "best mistakes".
Hospital accidents are common. Medical error, death and injury headlines are regular, predictable occurrences.	Hospital accidents are rare, with medical error death equivalent to airline and nuclear power plant performance.
Complexity makes it easy to do things wrong, hard to do things right (Institute of Medicine).	Well-designed workplace systems, structures and processes make it easy to do things right and hard to do things wrong.
Ultimate definition of quality endlessly debated, thus avoiding adequate measurement, management and improvement.	Consensus exists regarding a variety of key measures – including access to care, clinical outcomes, functionality, satisfaction and value received.
Quality can be improved by responding to each event and dealing with the "problem people". There is a silo for quality.	Quality is achieved by designing error proofing at the interface of people and processes. Everyone is in charge of quality.
Quality capability is seen almost solely in terms of professional skills – with virtual blindness to the importance of support systems.	Understands that carefully designed quality infrastructure is absolutely essential to reduce risk and optimize skills of professionals.
Quality improvement efforts are undertaken by silos in charge of quality monitoring.	Quality emanates from the careful design of clinical and operating processes and the coordinated skills of caregivers, patients and community stakeholders.
When major TQM/CQI efforts are undertaken with vigor, the existing system can reach 3 to 4 Sigma on quality. (3.5% to 7.5% error rates)	Transformed organizations, systems, people can reach 6 Sigma and beyond – to a 3rd curve of healthcare system design. (3.4 defects per million and better)
CEOs manage an organization within a network of healthcare services. Managers in silos talk past each other. Despite the rhetoric of co-operation, the rewards and incentives are for "winners" and "losers" and for those who play politics.	CEOs participate in facilitating a network of healthcare delivery organizations and provide strategic management and leadership to their own organizations. Silo managers integrate their planning and system design efforts. They are rewarded for achieving integration and for excellence in management.
Governance represents the self-interests of the organization.	Governance represents the "owners": the citizens/ community.
The system is designed to be complicated.	The system's complexities and self-organizing potential is realized in a natural <i>complex adaptive system</i> .



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Appendix C

Quick Facts About the Central Community Support Services Sector	
2007/08 Clients Served	33,509 * 53,000 **
2007/08 Total Units of Service	1,040,383 * (20,000+ services contacts every week)
Number of Programs from 2007 CSS Survey	170
2007//08 Central LHIN Funding	\$46 million 1.7% of total LHIN Budget (requires updating to including aging at home funding)
Number of Central LHIN Transfer Payment Agencies	33
Number of Transfer Payment Agencies Outside of C-LHIN providing Service within C-LHIN	27
Number of Central Community Support Services Network Members	44
Number of CSS Employees from 2007 CSS survey	1,400 +
Number of CSS Employees Involved in CSS Network and CBI Committees	35
Number of Home Support Workers, Personal Support Workers and Attendant Outreach Workers	Tbd
Number of Volunteers	7,000
M-SAA Performance Indicators	
(note many require development)	
<ul style="list-style-type: none"> • variance budget and forecast (\$) • variance budget and forecast (units of service) • proportion of budget spent on direct service • vacancy rate • turnover rate • service activity/volumes specific to functional centres • wait time 1 (from referral to assessment) • wait time 2 (from assessment to service) • client safety measure (eg. adverse events) • program outcome • patient experience • client outcomes/complaints 	<ul style="list-style-type: none"> • avoidable ER visits • cost per individual served • percent of LHIN population 75+ living in own home • governance indicator • volunteer capacity (eg. turnover) • referrals from hospital/CCAC to community CSS providers/programs • referrals to other agencies • clients attempting or accessing services from multiple agencies/on multiple waiting lists for programs • emergency department visits (avoidable) for community service provider clients

* Source: Central LHIN Health Service Needs Assessment and Gap Analysis Report, 2008 (does not include community support agencies providing services within the Central LHIN that are not Central LHIN transfer payment agencies)

** Community Support Services Network Survey, November 2007 (52 respondents including 32 Central LHIN transfer payment agencies)