North Simcoe Muskoka **LHIN**

Personal Support Services

Examining the Factors Affecting the Gap between Supply and Demand in North Simcoe Muskoka

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Ontario
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Introduction

For over ten years now, Ontario's health policy direction, particularly for seniors' care, has been shifting care out of institutions and into community. The focus has been on supporting individuals to live in the community for as long as possible, avoiding premature admission to long-term care homes and ensuring that those beds are used by those most in need. This shift aligns with information from numerous expert panels and what reports tell us patients and families want and has been supported by year over year increases to provincial funding for home and community care.

Personal support services[1] are pivotal to providing care that patients and families need, when they need it and where they want to receive it. Demand for personal support services across the long-term care continuum continues to grow. This is not surprising given the growing number of seniors. The number of seniors in North Simcoe Muskoka aged 65 years and over is expected to more than double over the next 20 years, from 93,000 in 2016 to over 177,500, or 29.3% of the population, by 2036.[2]

There is a long history of personal support worker[3] (PSW) shortages within the community support services (CSS) sector in North Simcoe Muskoka (NSM). In 2002, the CSS sector was approved to reduce service hours in order to implement a small wage increase for PSWs. There is no requirement that individuals providing services for CSS agencies are graduates of a recognized PSW education program. A variety of backgrounds and experience are acceptable qualifications and many CSS agencies have provided training internally.

Approximately three years ago, home care organizations in NSM began to experience a shortage of PSWs. At that time, while it was not a provincial policy requirement (MOHLTC 2006), the North Simcoe Muskoka Community Care Access Centre (NSM CCAC) contracts required that individuals providing personal support services were graduates of a recognized PSW education program. NSM CCAC hosted a focus group with contracted service providers to identify opportunities to increase personal support capacity. Service providers requested that NSM CCAC consider broadening the educational requirements for individuals providing personal support services to include other unregulated workers (such as home support workers, health care aides and developmental services workers). NSM CCAC agreed with the understanding that the service provider would ensure the individual staff's level of training and experience matched the needs of the patient and family so that quality of care and patient safety were not compromised.

Since that time, there have been isolated episodes of patients waiting for personal support services due to lack of human resources. Most often, these were situations where the patient's needs were complex,

1 Personal support services are provided by unregulated health care providers working in a variety of settings. Typically, they work under the supervision of a regulated health professional or supervisor, or under the direction of the patient. They provide assistance with personal care and other routine activities of daily living as well as basic homemaking services.

2 Data Source: Intellihealth, Ministry of Finance Population Projections

3 Throughout this document PSW is used to refer to any category of worker that is providing publicly funded personal support services to LHIN patients in CSS, home care and in long-term care.

requiring time-specific services, or in more difficult to serve, rural communities or a combination of these. Over the last several months, evidence suggests that the gap between the need for personal support services and the supply of qualified individuals is widening both in home and community care and in long-term care. North Simcoe Muskoka is beginning to experience the leading edge of a significant PSW shortage.

In response, the LHIN has launched a project focused on identifying longer term, sustainable strategies to reduce the gap between demand and supply. This includes understanding key drivers and identifying actions for improvement.

This report is the product of the first phase –*information gathering* – which summarizes key findings from a literature review, key informant interviews and quantitative analysis of demographic, home and community care and long-term care data. The details of the quantitative analysis can be found in the Technical Report.

This report is a key input into an action planning forum which will be held in the fall of 2017. Based on the findings from Phase 1, key stakeholders will be invited to participate in collectively identifying local actions. In addition, it is anticipated that opportunities for provincial action (e.g., service delivery model, policy considerations) will be identified. Local opportunities will be prioritized for implementation while recommendations regarding provincial opportunities and/or policy recommendations will be moved forward for further consideration.

Demand

Introduction

In 2016, the NSM LHIN was home to 485,734 residents or 3.5% of Ontario's population. By 2021, the population is projected to increase by 6.2%, 12.6% by 2026 and 24.7% by 2036. [4]

In 2016, 19.1% of NSM residents were seniors 65 years of age and over, up from 15.3% in 2011. By 2021, NSM seniors will account for 20.3% of the population; 23.3% by 2026. The number of seniors aged 65 years and over is expected to more than double over the next 20 years, from 93,000 in 2016 to over 177,500, or 29.3% of the population, by 2036.[5]

NSM LHIN performed an analysis of current utilization of personal support services across health care sectors with a focus on understanding the impact of the aging population on future demand. The analysis assumes that the contribution of each sector and the approach to providing care is consistent with the base year of the analysis (2016-2017). Projections are provided for community support services (CSS), home care, and long-term care homes. Data limitations make it difficult to project demand for retirement homes, other privately purchased services and acute care.

Community Support Service Agencies

Community support service agencies provide a range of programs and services to eligible individuals including attendant care, home support services, personal care, adult day programs, assisted living and supportive housing. Changes in the number of individuals in NSM receiving one or more of these services can often be traced back to strategic LHIN investments in specific programs. Between 2012-13 and 2016-17, the number of individuals attending adult day programs and receiving respite services increased significantly. The number of individuals served in assisted living dropped from 773 to 497 between 2012-13 and 2013-14. Since then the number has been steadily rising with 609 individuals served in 2016-17. These changes are reflected in the 15.2% increase in the number of attendance/resident days of care provided by CSS agencies between 2012-13 and 2016-17 (147,234 to 169,650 days). Over that same five year period, hours of care declined by 13.4%, down from 109,614 in 2012-13 to 94,957.[6]

It is estimated that 255 full time equivalents were required to deliver CSS care[7] (based on 1,950 hours of care per FTE per year) in 2016-17. Projections indicate that this will increase by approximately 45 more FTE by 2021-22. This is likely understated given recent LHIN investments in CSS services, particularly assisted living, supportive housing and transitional care beds. It is worth noting that length of stay in supportive housing is growing as clients wait for access to long-term care beds. And, key informants reported that wait times for attendant care outreach services in NSM are among the longest in the province.

[4] Data Source: Intellihealth, Ministry of Finance Population Projections
[5] Data Source: Intellihealth, Ministry of Finance Population Projections
[6] Data Source: Management Information System (MIS) reporting
[7] This analysis excludes direct ministry funded programs such as direct funding for attendant care services

Home Care

Home care data, both locally and provincially, demonstrates that the demand for personal support services continues to grow. In 2008-09, just under 19 million hours of personal support and homemaking services were purchased by CCACs in Ontario. In 2016-17, that number had increased by just under 58% to 29.8 million hours.[8] In NSM, the number of hours provided during the same time period increased by almost 82% from approximately 587,000 in 2008-09 to just over 1 million in 2016-17.[9] It is projected that demand for personal support in home care will increase by 3.3% provincially between the years 2016-17 and 2021-22 with an estimated 34 million hours of personal support required across the province in 2021-22. Demand will grow slightly faster in North Simcoe Muskoka at 3.7% with an estimated 1.24 million hours of personal support required in 2021-22.

In 2016-17 an estimated 526 full-time equivalents provided publicly funded long-stay home care services. It is projected that the size of this workforce will need to increase by 106 FTE (20%) by 2021-22 to 632.

This is likely a conservative estimate. In order to meet growing demand within available funding the average amount of personal support service patients receive has been declining in NSM since 2013-14. In 2013-14, a chronic patient would have received, on average, 16.16 hours of personal support per month and a complex patient would have received 32.10. In 2016-17, service levels have declined to an average of 13.13 for chronic patients and 28.62 for complex patients. NSM LHIN monthly average service levels are 10% (1.5 hours) below the provincial average for chronic patients (13.13 hours versus 14.65 respectively) and approximately 12% (3.8 hours) below for complex patients (28.62 versus 32.46).

Retirement Homes

As of August, 2017, there were 3,724 retirement home beds registered in NSM. Retirement homes play a significant role in the long-term care continuum. Currently, in NSM, approximately 12% of all home care personal support hours are delivered to patients living in retirement homes. This amounts to approximately 11,000 hours of care per month provided by LHIN contracted service providers. In addition, in 2016-17, there were approximately 337 full-time equivalents providing direct resident care in retirement homes. Projections indicate that the size of this workforce will need to increase by 59 FTE (17.5%) by 2021-22.

In the past four years, NSM has seen an 85.5% increase in the number of patients waiting for long-term care placement while living in a retirement home. Additionally, the proportion of long-term care home placements from retirement homes has increased, doubling over the past four years, representing just over one-third of all placements. Crisis placements from retirement homes have also increased dramatically. In 2016-17 over one-third of all crisis placements were for patients living in retirement homes.

Long-Term Care Homes

There are currently 26 long-term care homes in NSM with a total of 3,065 beds, approximately 2,978 of which are used for long-stay placements. The remainder are used for short-stay respite or convalescent care, or are interim in nature. The last addition of long-term care beds in NSM was in September, 2007 when Mill Creek Care Centre opened with 160 new beds. Unlike home and community care, long-term

8 Data source: Health Shared Services Ontario - MIS Reporting

9 Data source: Health Shared Services Ontario - MIS Reporting

care homes are required to hire only graduates of recognized personal support worker (PSW) education programs. It is estimated that 1,111 full-time equivalents of PSWs were required to staff long-term care homes in NSM in 2016-17. If new long-term care beds are opened to meet growing demographic pressures, this would likely increase by another 255 FTE by 2021-22.

The age profile of residents of long-term care homes in North Simcoe Muskoka is skewed heavily towards older age groups that are facing the fastest demographic growth over the next several years. In 2016, 74% of residents of NSM long-term care homes were 80 years of age or older and almost one-third (31%) were 90 years of age and older.

As of June, 2017, 1,762 individuals were waiting for admission to a long-term care home in NSM and an additional 639 were waiting for transfer to their preferred home. In the same month there were 54 new admissions to long-term care homes. The average wait time to placement ranged from 145 days for individuals who are in highest need of admission (priority 1) to 342 days for individuals who can still be supported at home until a bed becomes available (priority 4).[10]

NSM has seen a significant increase in both the number of individuals reaching crisis status prior to long-term care placement and the proportion of placements prioritized as crisis. Crisis placements in LTCHs have doubled in the last four years, accounting for 70% of placements. As noted above, the number of patients living in retirement homes while waiting for long-term care placement is also rising, up 85% from 634 in 2012-13 to 1176 in 2016-17, as are crisis placements from retirement homes.

Population aging in NSM is projected to increase demand for LTCH beds by 4.4% each year until 2021-22 and then remain steady at approximately the same rate for the next 20 years. This means that in order for LTCHs to make the same contribution, proportionately, to the long-term care continuum as they did in 2016, NSM would need to add approximately 130 to 140 new long-term care beds each year to 2021-22 and beyond. With no or few new long-term care beds scheduled to be opened in NSM in the next four years the number of long-term care home beds per 1000 people age 75 and over will decrease from 87.4 to 75.6. It is expected that this will drive increased demand for home and community care for chronic and complex patients.

Private Pay Home and Community Care

Very little information is available regarding the amount of home and community care that is privately purchased in Ontario each year. In 2013, the Ontario Home Care Association (now Home Care Ontario) estimated that a total of 54.5 million hours or visits of home care were publicly and privately funded in 2012-13. 34.5 million were funded by the Ministry of Health and Long-Term Care while 150,000 Ontarians purchased an additional 20 million visits or hours of home care services in order to remain at home. Stated differently, it is estimated that Ontarians privately purchase 1 hour or visit of home care for every 1.7 hours or visits that are publicly funded. This is in addition to care provided by family and other informal caregivers.

[10] Data Source: June 2017 Long-Term Care Home System Report from New CPRO, Health Data Branch, MOHLTC.

Demand Projections to 2021-22

Assuming that the contribution of each sector and the approach to providing care is consistent with 2016-17, it is estimated that an additional 406 unregulated workers (net new) will be required to meet growing demand for publicly funded home care, community care and long-term care by 2021-22. This does not include any increase in demand for retirement homes and other privately paid services.

As noted previously, given that NSM is not likely to see 680 new long-term care beds by 2021-22, it is reasonable to expect that unmet LTCH demand will materialize as increased demand for home care. If that is the case, it is estimated that a total of 777 FTE will be required to meet the demand for home care by 2021-22. That is an increase of 251 FTE or almost 48% more than in 2016-17.

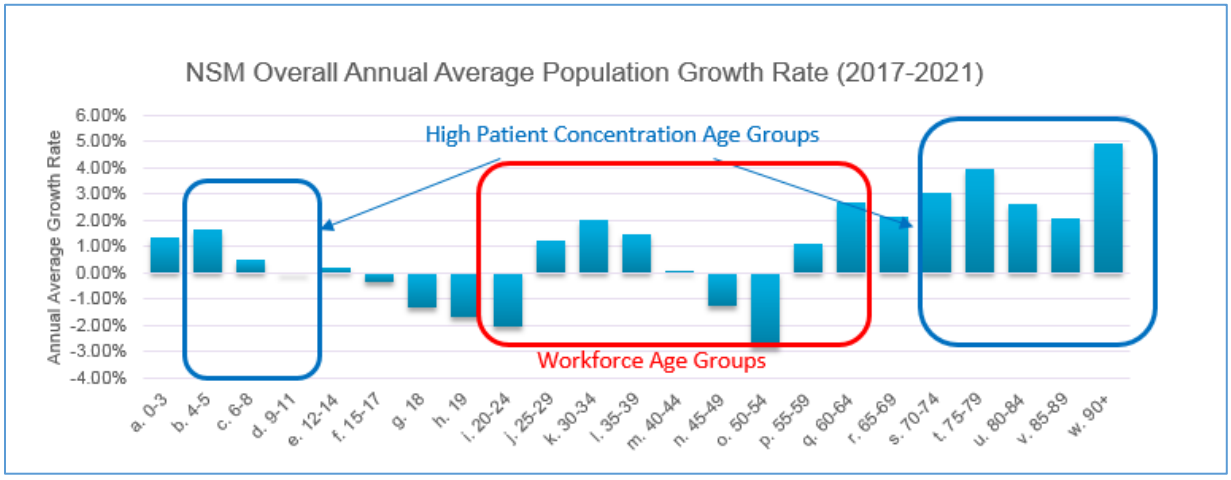
Sector	Estimated FTE 2016-17	Projected FTE 2021-22 (new LTCH beds)	Net New FTE	Projected FTE 2021-22 (no new LTCH beds)	Net New FTE
Community Support Services (CSS)[1]	255	300	45	300	45
Home Care[2]	526	632	106	777	251
Long-Term Care Homes[3]	1,111	1,366	255	1,111	0
Total	**1,892**	**2,298**	**406**	**2,188**	**296**

1. Actual FTE as reported through Ministry of Health and Long-Term Care Healthcare Indicator Tool
2. Estimated using actual paid PSW hours provided to long-stay patient population (complex, chronic and community independence)
3. Estimated using average residents, assuming 2 personal support hours/day/resident and 1,950 hours/FTE

Supply

Demographic Trends

In the five year period between 2016-17 and 2021-22 NSM's expected annual population growth rate is 1.02%. However, the working age population (age 20 to 64) is projected to grow at just 0.4% and the age cohorts most likely to become PSWs are showing the slowest demographic growth or largest demographic decline. Over that same time period, the number of patients receiving home care is projected to grow at 3.24%. Demand for personal support services is projected to grow nine times faster than the workforce.



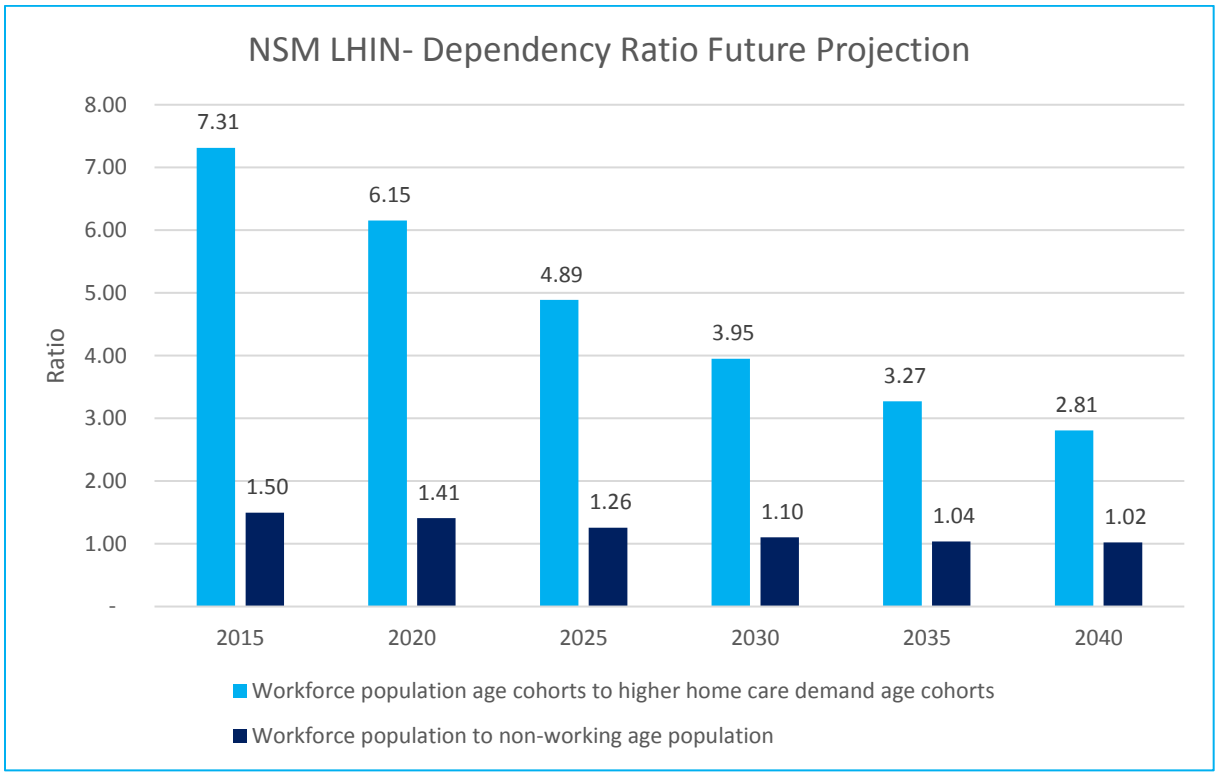
Between 2016-17 and 2036-37, NSM's population is projected to grow at an annual average rate of 0.98%, while the working age population is projected to grow much slower at just 0.16% and the home care patient population much faster at 3.21%. Over the next 20 years, demand for personal support services is projected to grow more than 20 times faster than the workforce.

Population growth is not distributed equally among the NSM sub regions. Population growth in Muskoka is expected to be slower than other sub-regions at 0.62% and growth in home care patient population here will also be slower at 2.73%. However, the workforce population in Muskoka is actually expected to decrease in the next five years by approximately 0.36%. Twenty year projections are very similar with 0.61% growth in population, 2.62% growth in the home care patient population and a 0.44% decline in the working age population.

In all other sub-regions (population projections are not available at the sub-region level in Simcoe County), the short term (2016-17 to 2021-22) average annual population growth rate is projected to be 1.08% with 3.03% increase in the home care patient population and 0.35% growth in the working age population. In the longer term (2016-17 to 2036-37) average annual population growth rate and the increase in the home care patient population is expected to remain relatively constant (1.03% and 3.02% respectively) while the growth in the working age population will fall to just 0.18%.

Dependency ratios also help us to understand how the supply of workers may be changing. In 2015-16, there were 285,204 working age persons in NSM and 190,472 non-working age persons or 1.5 working age for every one non-working age person. Over the next 25 years, the number of working age to non-working age will decline by approximately 30%, from 1.5 to 1.02.

We also looked at dependency ratios for high demand home care populations. In 2015-16 there were 7.31 working age persons for every person in the highest home care demand age groups (75 years and over). Over the next 25 years this is expected to decline to just 2.8 to 1.



Demographic Profile of Personal Support Workers

In 2009 the Canadian Research Network for Care in the Community (CRNCC) collaborated with the Personal Support Network of Ontario (PSNO) and the Ontario Community Support Association (OCSA) to conduct a survey of PSWs; 364 PSWs from across all health care sectors in Ontario responded. While the authors cautioned that the sample was not random and the information should not be generalized to the broader PSW population, the information gathered does provide a very informative picture of the demographic profile of the respondents.

Ninety six percent (96%) were female. Seventy four percent (74%) were 40 years of age or older with just under 45% 50 years of age or older. The average age was 45.6 years. Forty four percent (44%) had worked as a PSW for more than 10 years and almost 50% of respondents indicated that they planned to work as a PSW “indefinitely”. The study found that, broadly speaking, PSWs reflected the ethnic and racial diversity of Ontario. However, visible minorities were over-represented, making up 42% of the

labour force versus 23% of Ontario's total population. Five percent (5%) of PSWs self-identified as aboriginal.

Contracted home care service provider representatives identified that PSWs employed by them were primarily female with a large proportion heading single parent families. The average age across agencies, ranged from 44.8 years to 47 years. Sixty four percent (64%) were 40 years of age or older and approximately 41% were 50 years of age or older. Contracted service provider representatives indicated that it was not unusual to have staff work into their 70's. Not all agencies tracked the number of years worked as a PSW and those that did tracked it for their own agency only.

The picture in long-term care homes was very similar with key informants indicating that the average age of their PSWs ranged from 35 to 55 years.

Education, Orientation and Training

Education

There is no singled standardized curriculum for PSW education in Ontario. In 1997 the Ministry of Health and Long-Term Care approved the first PSW curriculum, consolidating the Health Care Aide and Home Support Worker training programs. The Ministry of Advanced Education and Skills Development (MAESD - formerly Ministry of Training, Colleges and Universities) is responsible for developing and monitoring educational standards for PSW training programs offered in community colleges across the province, including compliance oversight of private colleges. What we heard is that the ministry establishes "vocational learning objectives" and it is up to each school to translate those objectives into programming. The Ministry of Health and Long-Term Care also recognizes two other sets of PSW vocational standards: the National Association of Career Colleges (for courses delivered by private vocational schools) and the Ontario Community Support Association (OCSA) (for courses delivered by Catholic or Public School Boards offering continuing education for adults). Boards of Education can choose between the MAESD and OCSA standards for their programs.

All three types of PSW education programs are available in North Simcoe Muskoka and area. Georgian College offers programs in Barrie, Midland, South Georgian Bay, Muskoka, Owen Sound, Alliston and Orangeville. The Simcoe County District School Board offers programs through the Learning Centres in Barrie, North Simcoe (Penetanguishene), Orillia and Alliston. Trillium Lakelands District School Board offers programs in Lindsay and Peterborough (in conjunction with Kawartha-Pine Ridge District School Board). These programs also offer students the opportunity to achieve both a high school and a college credit (dual credit) upon successful completion of the PSW Foundations course. A number of career colleges also offer programs in North Simcoe Muskoka, primarily in the Barrie area.

Key stakeholders from educational institutions reported that they have more capacity than interest. In some geographic areas programs have been cancelled or run with less than the minimum enrollment. Notably, programs were cancelled in Muskoka and fewer programs were run in South Georgian Bay and Orillia this past year. We also heard that enrollment was down in the Midland area. We heard that both

the college and adult learning centre programs collaborate with the high schools to expose students to personal support work as a career choice.

Key informants indicated that the majority of applicants are mature students, aged 25 years and up, with many 35 to 45 years of age. Many are single parents, primarily female, who face a number of challenges in completing the program. We also heard that an increasing number of individuals with English as a second language (ESL) are applying to these programs. Changes to the Ontario Student Assistance Program (OSAP) announced in March 2016, have helped to remove barriers related to the cost of tuition. It is worth noting that individuals attending training through the Ontario School Board programs are not eligible for OSAP. However, other barriers remain, such as, loss of income during the program, required access to transportation for clinical placements and daycare arrangements that accommodate split shifts.

Key informants indicated that there are many individuals who are very interested in working as PSWs who have significant experience as informal caregivers and are truly "called" to this work but do not want to return to school to undertake a formal education program. Both Georgian College and Simcoe County District School Board programs recognize prior learning. We heard that the PSW program was originally designed to be modular and has evolved, and that there is opportunity to look at how the program is delivered to maximize the value of prior learning. Key informants stressed that the programs need to be flexible to reduce barriers to entry and program completion. We heard that the "Second Career Program" has historically produced applicants for PSW training programs and that they may not always have been the best fit. We heard that often "their heart and soul isn't in it". A search of the Ontario Government's Second Career website (http://www.secondcareerontario.com/web/second_career/landing/default.aspx - Sept. 14, 2017) revealed that personal support workers are not included in the list of "careers that may quality for Second Career funding in Ontario". "Licensed Practical Nurse" is. A search of schools in NSM under the "Health" category reveals a page which includes one career college in Barrie offering personal support worker training but interestingly does not include the local college and adult learning centre programs.

We heard that the majority of students choose employment in the sector in which they completed their clinical placement (one key informant placed this at 98%). We learned that there are significant barriers to PSW students completing their clinical placements in the home care sector. This includes the need to have access to transportation, coupled with the inability of staff of contracted service provider organizations to transport students in their vehicles, the availability of college mentors to support the student and preceptor given the unpredictability of PSW schedules (split shifts, last minute cancellations and changes), and acceptance of students on the part of home care patients and families. Many of these barriers do not exist in long-term care. We also heard that long-term care homes can, and frequently do, hire individuals who are working through an accredited program and have completed their first 110 hours of clinical placement. The students are then able to use work hours to fulfill the remainder of their placement requirements.

Key informants noted that the attendance requirement at school is 80%. They are seeing graduates continue this attendance expectation into the workplace.

We also heard that new graduates are not well prepared for the demands of the role in long-term care homes. In their practicum placements students are responsible for four patients. Typically a PSW in a long-term care home would be responsible for up to 8 patients on a day shift and 32 on nights. Key informants stressed the toll that this takes on the staff who are mentoring these new staff.

Orientation & Training

Key informants spoke to the importance of a good onboarding experience in retaining new staff. All home care, community care and long-term care key informants indicated that they had a formal orientation program for new hires, many of which included alignment to a preceptor or mentor. Only one indicated that they had a formal mentorship program in which staff who mentored were given formal education and recognition.

The complexity of patients is increasing across the long-term care continuum. Subsequently PSWs are increasingly providing specialized care. In the 2009 CRNCC survey, PSWs indicated that they would benefit from enhanced training in areas such as mental health, chronic disease management, medication management, LGBTQ seniors, dementia and palliative care. Long-term care homes, in particular, spoke of the increasing prevalence of dementia, mental illness and dual diagnosis with significant investments made in training to manage responsive behaviours, such as Montessori and Gentle Persuasive Approaches (GPA).

Key informants spoke about the PSW Bridging Fund, expressing concerns in two areas: the type of education the funding can be used to support and how the fund is managed. We heard that historically the funding was used for bridging from other training programs (home support worker, health care aide) to a recognized PSW training program. Now the funding is used more for professional development and training, although training seen to be the responsibility of the employer (e.g., safe food handling, first aid) is not eligible. In addition, we heard that the funding can only be used to support training for graduates of recognized PSW education programs.

Key informants identified that it is not unusual to "send funding back" each year because it is confirmed too late to allow for appropriate planning and implementation of training programs. We heard that the funding is flowed to 15 "bankers" across the province and it is unclear whether the funding is equitably distributed and/or sufficient. The funding available for NSM is managed by one community support service agency who, in alignment with the framework set out by the ministry, undertakes a call for, and evaluation of, proposals. It was suggested that it may be more effective for the ministry to flow the funding to the LHINs to allocate.

Recruitment and Retention of Personal Support Workers

The literature is replete with references to barriers to PSW recruitment and retention, particularly in home and community care, and calls to develop plans/programs to ensure an adequate workforce to meet the needs of an aging population. In 2008, the Joint Community Care Access Centre (CCAC)/Service Provider Association Committee made a submission to HealthForce Ontario identifying that the "supply of people to provide care is the most important issue facing the health system" and proposing a blueprint for action. In 2011 Torres identified that "recruitment and retention of Personal Support Workers (PSWs) in long-term care and especially in homecare is a longstanding issue and one which the literature indicates should also be seen as a priority". She recommended multi-ministerial coordination and collaboration in PSW human resource planning. In 2015, The Expert Group on Home & Community Care noted that it was becoming increasingly difficult for contracted service providers to attract and retain qualified staff. Also in 2015, the Ontario Ministry of Health and Long-Term Care, through the PSW Workforce

Stabilization Strategy, committed to looking more closely at challenges that affect PSW recruitment and retention.

Data obtained from NSM contracted SPOs suggests that turnover in PSWs in home care is around 25% to 28% per year. Key informants cited turnover in long-term care homes in NSM as "high" with one home reporting approximately 20%. We heard from all stakeholders who employ PSWs that the long standing employees are the ones who pick up extra shifts/visits when the organization is short staffed.

The following summarizes the key issues and concerns related to PSW recruitment and retention identified through a literature review and key informant interviews.

Wages

Long-term care homes are more attractive to PSWs because of better wages, benefits, working conditions and employment security (OHHRRN, 2011, 3(2); Panagiotoglou, 2017). Available information suggests that PSWs working for contracted home care service providers in NSM are paid, on average, $16.50 to $19.00 per hour. Key informants identified that the hourly wage for PSWs working in long-term care homes in NSM currently ranges from approximately $18.00 to $24.00 per hour. One acute care hospital in NSM indicated that their rate of pay for PSWs was approximately $24.00 per hour. There is a disconnect between Ontario's health policy direction to shift care to home and community and practices in the marketplace to pay workers higher wages in facility based care (Keefe 2011).

Panagiotoglou et al (2017) recently undertook a study looking at job satisfaction for "home support workers" in Canada. They reported that "overall" PSWs described their rates of pay as "satisfying". However, respondents expressed concern regarding their ability to achieve a "livable income from week to week". Study participants expressed a desire for incomes that aligned with the cost of living in their communities. Local contracted service provider key informants spoke to the economic pressure for their staff created by the rising cost of housing in many parts of North Simcoe Muskoka.

Key informants also identified that concerns regarding the ability to generate a stable paycheck caused some PSWs to work for more than one employer. This offered them a "foot in the door" while waiting for a full-time opportunity to become available. In the case of PSWs working in home care, often, the second employer was a retirement home or long-term care home. One key informant expressed concern for patient safety indicating that they closely monitored those staff that they knew were working for more than one employer. There is, however, no requirement for staff to disclose this.

The wage disparity between home care and long-term care was highlighted by the Honourable Elinor Caplan in her 2006 review of competitive procurement in home care. In response, the Ministry of Health and Long-Term Care increased the minimum wage for personal support workers who were providing services under contract to the CCAC to $12.50 per hour. In 2014, the Ontario Government launched a new PSW stabilization strategy which resulted in a $4.00 per hour increase over a three year period for PSWs who work in home and community care settings. The minimum PSW wage in home and community care, for publicly funded direct care, is now $16.50 per hour. This is approximately 42% higher than the current basic minimum wage in Ontario of $11.60. The Ontario government recently

announced their intent to increase the basic minimum wage to $15.00 per hour by 2019. Should those increases be realized, the gap between the PSW and basic minimum wage would be reduced to just 10%.

Unpredictability in scheduling was also identified as a significant variable in determining income. The Canadian Research Network for Care in the Community (CRNCC's) 2009 survey found that the three highest ranked reasons for leaving the profession related to pay, scheduling and hours. Scheduling and full-time employment opportunities will be discussed in more detail later in this report.

Benefits

Generally speaking all home care, community care and long-term care key informants identified that full-time employees were eligible for benefits while part-time employee benefits were pro-rated based on hours worked or paid as a percentage in lieu.

In 2007 the Ministry of Health and Long-Term Care established standards for home care personal support service volumes to be delivered by full-time and part-time staff. These standards were to be achieved by March 31, 2011. Ten percent of service volumes are to be delivered by full time (FT) workers, defined as working at least 30 hours per week, averaged over a two-week pay period. Twenty percent of service volumes are to be delivered by part-time (PT) workers, defined as at least 15 hours per week, averaged over a two-week pay period. Contracted service provider informants did not provide specific information regarding FT and PT complements. For contracted service provider organizations, who just meet the standard, up to 70% of the hours of service they deliver would be provided by staff not eligible for benefits. One key informant expressed concerns that uncertainty in scheduling that caused a reduction in hours could result in a PSW losing their benefits.

Pensions

Significant variation exists in access to pension plans for PSWs across the long-term care continuum. Several contracted home care service provider organizations indicated that there was no pension plan and several others indicated that there was the option of contributing to a group retirement savings plan (RSP). A small number of organizations indicated that employee contributions to the RSP are matched by the employer, to a ceiling amount (one cited $1,000 per year). Where a group RSP exists, only full-time (FT) and part-time (PT) employees who worked a minimum number of hours per week were eligible to participate.

In long-term care, all key informants cited that full-time employees had access to a pension plan. These were primarily defined contribution plans, with contribution matching by the employer. The municipal homes were the exception, where employees had access to a defined benefit pension plan (OMERS). Part-time employees primarily received a percentage in lieu.

Full Time Employment

Key informants identified that the lack of full-time opportunities is a problem across the long-term care continuum. Contracted home care service providers identified that the fee-for-service contract model,

with no guarantee of visits, makes it too risky to hire more full-time staff. One key informant shared that they can only offer full-time employment to staff that are willing to work "split-shifts". Another told us that that the majority of their staff are FT, despite the lack of guaranteed hours and use dynamic scheduling to provide full time hours. We also heard that in CSS and long-term care, it is very difficult to hire directly into full-time jobs. As the shortage of PSWs becomes more pronounced, there is a heavy reliance on part-time and casual staff and over-time to fill vacant spots in schedules. Some have also resorted to using staffing agencies. Most key informants expressed a desire to be able to hire more full-time staff.

Scheduling

Key informants frequently cited scheduling as a barrier to recruitment, retention and positive work life experience for PSWs working in home care. Three aspects to scheduling were identified as concerns: shorter visits, split shifts and unpredictability (i.e. short notice cancellations). The profile of patients receiving home and community care in Ontario has shifted substantively over the years. In 2008-09, approximately 35% of patients receiving home care had high care needs. In 2014-15, that had increased to almost 69%.[11] In addition, more patients with greater needs coupled with fiscal pressures has changed the way in which services are scheduled and provided.

Increasingly, home care personal support services are delivered in one hour blocks and less than that in cluster care sites[12]. More, shorter visits increases travel time for PSWs. The 2013 Accenture Fee-for-Service Market Assessment Report found evidence that referral patterns were changing over time with "shorter visits becoming more prevalent" and that SPOs "were not being paid for the full cost of travel". Travel will be discussed later in this report.

Complex patients require assistance to get out of bed, bathed and dressed in the morning and returned to bed in the evening; this pattern is often referred to as "rising and retiring care". In addition, we are beginning to see more patients who require two PSWs to provide care at each visit due to the complexity of care that is required and to support patients to remain safe at home. (e.g., transfers). This is resulting in significant time-sensitive demands in the early morning and early evening with little work in between. Key informants indicated that while some PSWs like the flexibility that "split-shifts" offer (can run errands etc.), they can create significant personal challenges (e.g., day care, car sharing, balancing personal commitments) resulting in job dissatisfaction. We also heard that split-shifts make it difficult to support community placements for PSW students.

All contracted service provider informants indicated that there is unused capacity from approximately 11:00 am to 4:00 pm. In 2013, with funding support from the NSM LHIN, NSM CCAC implemented a strategy to provide personal support services to lower need patients who had been waiting for service. NSM CCAC consulted patients on whether they would be willing to accept some service whenever the contracted service provider agency could provide it. Overwhelmingly, patients responded positively and the strategy was very successful both in improving access to service for patients and in improving work life experience for PSWs.

[11] Data Source: HSSOntario

[12] Cluster care site – There is no standard provincial definition for cluster care in home care. In NSM this term refers to a setting where multiple patients reside.

However, demand for service in off-peak hours remains low and demand for "rising and retiring care" remains high, necessitating that PSWs continue to work split-shifts in order to maintain their income and full time hours. The Employment Standards Act (ESA) requires that employers provide an 11 hour rest period in each 24 hour period. This means that an employee that begins their day at 6:00 am must be finished their second shift by 7:00 pm. A single employee cannot provide care at both ends of the high demand periods in a day – 6:00 am to 12:00 pm and 6:00 pm to 10:00 pm – and be in compliance with ESA.

In 2014, new regulations under the Home Care and Community Services Act, 1994, gave the Ministry of Health and Long-Term Care and Local Health Integration Networks the authority to shift the delivery of personal support services for lower need patients to community support service (CSS) agencies. Implementation of this initiative should be approached with full consideration of the impact on scheduling and the potential to exacerbate the "split-shift" issue.

A PSW may begin their day with a full schedule (7-8 hours) but there is no guarantee that is how their day will end. Visits may be cancelled with very little notice due to a number of reasons (e.g., patient had a change of status and had to go to the emergency department or forgot they had an appointment). Data from the Client Health and Related Information System (CHRIS) reveals that, in NSM, approximately 13% of personal support visits booked do not get paid. If there is no service request to fill the cancelled visit, the PSW loses that visit from their schedule and, subsequently, the associated income. Conversely, if several new requests for service, particularly complex ones, are received, PSWs are asked to add additional hours of work to their day with very little notice. In the words of one key informant, "PSWs are either burnt out or can't pay their mortgage".

Travel

The nature of home care, and some CSS, personal support services requires that workers travel from one patient's home to the next throughout the work day. We heard travel related concerns in two areas: financial impact and personal safety.

North Simcoe Muskoka covers an area of 8,445 square kilometres and, in 2015, was home to 475,676 people. Nearly one-third of NSM residents live in rural areas. (NSM LHIN 2016) There is limited ability to travel between patient visits using public transit. Even within urban centres where public transportation exists, transit schedules are not frequent enough to support their ability to see patients as scheduled. Perhaps with minor exceptions, workers providing home and community care in NSM must have access to a vehicle. The Canadian Automobile Association (CAA) estimates that the cost to operate a compact car in Ontario, based on driving 20,000 km, is $8,940 annually. This includes the cost of fuel, insurance, licensing and registration and depreciation and maintenance (http://caa.ca/car_costs/).

In 2007, the Ministry of Health and Long-Term Care released a new Client Service Procurement Policy for Community Care Access Centres. The policy stated that CCACs must require that "Service Providers reimburse personal support workers/homemakers for travel time from client to client as required by the Employment Standards Act". A search of the Employment Standards Act, 2000 (https://www.ontario.ca/laws/statute/00e41) returned no matches for "travel". Information on the Ministry of Labour website provides clarification of what constitutes "travel time" for it to be considered to be "work time" (https://www.labour.gov.on.ca/english/es/tools/hours/what_counts.php).

What we heard from contracted service provider representatives and community support services suggests that there is tremendous variation in how travel time and/or mileage are compensated. Some identified that they paid travel time but not mileage. One key informant stated that they paid both but travel time was compensated at a different rate and it "wasn't much". In 2013, the Accenture Report identified that "workers who deliver home care travel to different areas and patients, often fully or partially at their own expense". No key informant shared specific information regarding compensation rates for travel time and/or mileage.

As noted earlier, more and more personal support is being delivered in one hour blocks. This has the unintended consequence of increasing the percentage of travel time in a work day. If travel time is not compensated at a PSW's regular hourly wage rate, increasing travel time will either reduce their income or require that they work a longer day to offset the difference.

Lastly, we heard concerns related to safety when travelling, primarily related to winter hazards. We also heard concerns related to personal safety when travelling into unknown neighbourhoods, particularly during twilight when there is less light and a reduced ability to more easily observe the surroundings. In the words of one PSW interviewed by Panagiotoglou et al. (2017) "My main concern is safety in travelling and late evenings. Just because people have gotten so crazy over the years with the violence and stabbings, shootings".

Personal Safety/Injury

For PSWs in home and community care, in addition to personal safety concerns related to travelling, we heard a lot about concerns for personal safety related to working alone in patient's homes. As noted in the 2009 CRNCC PSW study, working in patients' homes "introduces different challenges, which can potentially create elements of unpredictability and risk". The literature speaks to the range of personal safety concerns including exposure to second hand smoke and cleaning chemicals, unhygienic environments, pets, illegal behavior including drug use, presence of firearms, verbal abuse including discrimination and racism, physical aggression and physical/sexual assaults. CRNCC (2009) reported that 86% of PSWs surveyed indicated that they "always" or "often" felt safe in their workplace, 2.3% never felt safe and just under 12% felt safe from "time to time".

In 2011, the legacy NSM CCAC worked with contracted service providers to develop a framework for managing situations or issues in the patient's care environment that had the potential to cause physical harm or expose CCAC or service provider staff to harassment or violence. Panagiotoglou (2017) noted that support to "not have to put up with that abuse" and "leave now" when threatened in the home went a long way to ensure PSW safety and confidence in their supervisors and agencies. Key informants indicated that PSWs "stay" when they are able to establish strong rapport and relationships with supervisors who follow up on their concerns.

NSM LHIN tracks the number of reported home care staff related risk events (both LHIN and contracted service provider). The rate was steady between 2012-13 and 2015-16 at 0.01 per 1,000 hours of service. In 2016-17, the rate doubled to 0.02 per 1,000 hours of service and the number of reported incidents of physical/sexual assault increased over three fold from an average of 2.5 per year between 2012-13 and 2015-16 to nine in 2016-17. Five of the nine incidents involved physical violence such as pushing, punching, slapping and scratching. Four involved sexually inappropriate comments and touching. Two of the nine incidents involved someone other than the patient (e.g., family member). It is unclear whether the

increase reflects an actual increase in incidents or improved reporting. What we heard is that the prevalence of dementia and behaviours among home care patients is increasing, and this is increasing the risk of harm to staff.

An analysis of long-stay home care patients in North Simcoe Muskoka found that the while the number of patients with dementia and/or behaviors increased between 2012-13 and 2016-17, the proportion of total long-stay patients[13] remained relatively constant. However, the proportion of long-stay patients with no or minimal cognitive impairment (Cognitive Performance Scale – CPS 0-1) fell by 5% while the proportion with mild impairment (CPS 2) increased by 5% over the same five year period. Perhaps the most significant finding was that the number of patients with psychiatric disease increased both in number and as a percentage of long-stay patients between 2012-13 and 2016-17 from 23% (n=873) to 28% (n=1,564).

Anecdotally, long-term care home key informants identified similar trends with an increase in psychiatric diagnoses, dementia, dual-diagnosis and responsive behaviors. They reported an increasing trend in safety events involving residents scratching, hitting, biting and spitting at staff.

Scope of Role

The profile of patients supported at home and residents of long-term care homes has evolved considerably over the last 20 years. So has the role of PSWs. PSWs are increasingly providing specialized care through a process of delegation involving the transfer of skills from a regulated health professional to an unregulated worker. Delegation requires patient specific training by a regulated health professional, often a supervisor, and cannot be transferred to any other patient[14]. The most commonly transferred or delegated skills include transfers, simple wound care, exercises, catheterization, colostomy care, compression stockings, G-tube feeding and continence care (Denton, 2011).

The literature speaks to a number of considerations around the delegation of acts including concerns for patient safety and quality and the health and safety of PSWs as well as factors related to education and training, supervision and fair compensation. Key informants stressed the importance of strong supervision in supporting PSWs to work independently in providing care to complex patients.

In 2005, the Minister of Health and Long-Term Care asked the Health Professions Regulatory Advisory Council (HPRAC) to "review the range of work carried out by Personal Support Workers and make initial recommendations on whether all or some part of this range would indicate that Personal Support Workers should be considered for regulation under the Regulated Health Professions Act, 1991". HPRAC found that the "PSW occupation does not operate within its own clearly defined body of knowledge" and recommended that PSWs should not be regulated as a profession.

Recognition and Respect

We frequently heard that PSWs want to be respected as an important member of the interdisciplinary team. They would like to have a greater role in health care planning for their patients and to be able to engage directly with other members of the interdisciplinary team rather than through a coordinator or supervisor.

[13] Long-stay adult patients who received personal support services and had a RAI-HC assessment in the fiscal year, including complex, chronic and community independence populations.
[14] Attendant care workers are able to perform restricted acts under an exception clause in the Regulated Health Professionals Act.

Supervision

Key informants talked about the importance of the relationship between PSWs and their supervisors in retaining staff. This was echoed in the literature with references to the importance of good communication, clarity in job description and expectations, feedback regarding performance and support when dealing with challenging situations.

Patient and Family Expectations

We heard that patient and family expectations are changing and significantly impact a PSWs work-life. Long-term care placements are occurring at a later age and patients have more complex needs. In many instances, families have been providing care to their loved one and expect that care will continue to be provided the way they provided it. We heard that, often, those expectations are not realistic due to staffing levels. The pace in long-term care homes results in PSWs feeling like they can't provide care to the level families expect and that they would like to provide; they constantly feel like they have failed; it is demoralizing.

We also heard that families are more distrustful of long-term care home staff. Key informants reported that more and more families are providing PSWs with written directions for care, documenting their conversations and/or hiding video cameras in residents' rooms. This reinforces feelings of not being valued, inadequacy and failure.

In home care, we heard that many patients still see the role of the PSW as it was in the mid 1990's when patients receiving homemaking and personal support services were less complex and services were commonly provided in blocks of several hours with a significant emphasis on assistance with instrumental activities of daily living (IADLs) (i.e. homemaking, shopping, meal preparation, laundry). Since that time, the complexity of patients served has increased, demand for services has increased and, as noted earlier, services are now commonly authorized in one hour blocks or less. The focus is on assistance with activities of daily living (e.g., bathing, dressing, transfers, feeding and toileting) with very limited time to assist with IADL's. This is contributing to misaligned expectations and dissatisfaction of the part of both the patient and family as well as the PSW. Key informants also indicated that this "time for task" approach is leading to decreased job satisfaction, indicating that what PSWs want most is to ensure that they have the time to provide what their patients need. One key informant indicated that targeted funding with volume commitments reinforces "time for task" and limits the delivery of holistic care. We also heard that "up-credentialing" can contribute to a mis-match between patient need for support with IADLs and worker expectations. "They don't want to mop the floor and do the dishes."

Key Findings

Demand

- The number of seniors aged 65 years and over in NSM is expected to more than double over the next 20 years, from 93,000 in 2016 to over 177,500, or 29.3% of the population, by 2036.
- Assuming that approaches to care provision remain consistent, NSM will need 406 (21.5%) more PSWs providing care by 2021.
- With no/few additional long term care beds planned for NSM, the need for community based care is expected to increase exponentially.

Supply

Demographic Trends

- PSWs in Ontario are primarily female and almost three quarters are 40 years of age or older.
- Between 2015-16 and 2021-22, demand for personal support services in NSM is projected to grow nine times faster than the workforce.
- Between 2015-16 and 2035-36, demand for personal support services in NSM is projected to grow twenty times faster than the workforce.
- Population growth is not distributed equally among NSM sub-regions. The workforce in Muskoka is projected to decrease in both the short and longer term (5 and 20 years).

Education, Orientation & Training

- There is no standardized curriculum for PSW education in Ontario.
- Ministry established vocational learning objectives.
- PSWs can attend community college, an organization affiliated with a school board or a private career college to obtain the training required to become a PSW.
- The length and cost of the program varies among educational institutions.
- Structure of the programs makes it difficult to optimize prior learning assessment.
- Barriers to entry include cost of the program, loss of income during the program, access to transportation for clinical placements, daycare arrangements that accommodate split shifts.
- Due to ease of scheduling and supervision, most placements are completed in long term care.
- Most PSWs continue working in the organization where they completed their placement.
- Graduates are not well prepared for the demands of the role in long-term care homes.
- Consistent use of preceptor and/or mentors in onboarding new staff.
- Limited use of formal preceptorship/mentorship programs.

- Patient complexity is increasing. PSWS would benefit from enhanced training in areas such as mental health, chronic disease management, medication management, LGBTQ seniors, dementia and palliative care.
- The value of the PSW Bridging Fund could be enhanced through flexibility to support broader training needs and improved management.

PSW Recruitment and Retention

- High variability in wages, benefits, pensions and other compensation between sectors that employ PSWs.
- In terms of straight wages and benefits, acute care is highest, while community is the lowest.
- Currently, the PSW minimum wage for publicly funded PSWs in home and community care is 42% higher than the basic provincial minimum wage. The planned increase in the basic minimum wage in Ontario will reduce this to just 10%.
- A disconnect exists between Ontario's health policy direction to shift care to home and community and practices in the marketplace to pay workers higher wages in facility based care.
- A limited number of full time positions exist in all sectors.
- Many PSWs work for more than one employer. This offers a "foot in the door" while they wait for a full-time opportunity.
- Unpredictability in scheduling and willingness to work split-shifts are significant variables in determining income for PSWs working in home care.
- Pay, scheduling and hours ranked highest among the reasons for leaving the profession.
- PSWs working in home and community care are required to travel to patients homes. This raises concerns related to the financial impact and personal safety.
- PSWs in long term care and community are seeing an increase in the number of patients who exhibit behaviours and have diagnoses that impact care provision.
- There is an increasing trend in staff safety events, including physical and sexual assaults.
- The PSW role is evolving to increasingly provide specialized care through a process of delegation from a regulated health professional.
- All stakeholders who provide direct care indicated that family/caregiver expectations impact their work and role fulfilment.
- Literature supports, and PSWs feel, they play a pivotal role in the interdisciplinary team but are not consistently recognized for this or included in care planning.

Key Informants

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