July 13, 2018

Dear Applicant:

Re: Your request for access to information under Part II of the Access to Information and Protection of Privacy Act [Our File #: HCS/084//2018]

On June 15, 2018, the Department of Health and Community Services (the Department) received your request for access to the following records:

“Deloitte LLP was commissioned to prepare report(s) on the administration of self-managed care in the home support sector as well options for the introduction of electronic visit verification systems in agency-provided care and/or self-managed care. I am requesting a copy of this report(s), which would have been prepared and submitted to Government sometime in the last 12 months, as well as copies of any presentations and briefing notes related to same.”

I am pleased to inform you that a decision has been made by John G. Abbott, Deputy Minister for the Department, to provide access to some of the requested information. Access to the remaining information contained within the records, has been refused in accordance with the following exceptions to disclosure, as specified in the Access to Information and Protection of Privacy Act (the Act):

**Policy Advice or Recommendations**

s. 29(1)(a) - The head of a public body may refuse to disclose to an applicant information that would reveal advice, proposals, recommendations, analyses or policy options developed by or for a public body or minister.

Please be advised that the remainder of the request has been withheld under section 22(1)(b) of the Act which states:

s. 22(1)(b) - The head of a public body may refuse to disclose a record or part of a record that is to be published or released to the public within 30 business days after the applicant’s request is received.

Please be advised that the requested report shall be made publicly available within the 30 business days after your request was received.

Please be advised that you may ask the Information and Privacy Commissioner to review the processing of your access request, as set out in section 42 of the Act. A request to the Commissioner must be made in writing within 15 business days of the date of this letter or within a longer period that may be allowed by the Commissioner.
The address and contact information of the Information and Privacy Commissioner is as follows:
Office of the Information and Privacy Commissioner
2 Canada Drive
P. O. Box 13004, Stn. A
St. John’s, NL. A1B 3V8
Telephone: (709) 729-6309
Toll-Free: 1-877-729-6309
Facsimile: (709) 729-6500

You may also appeal directly to the Supreme Court Trial Division within 15 business days after you receive the decision of the public body, pursuant to section 52 of the Act.

Please be advised that responsive records will be published following a 72 hour period after the response is sent electronically to you or five business days in the case where records are mailed to you. It is the goal to have the responsive records posted to the Completed Access to Information Requests website within one business day following the applicable period of time. Please note that requests for personal information will not be posted online.

If you have any further questions, please contact the undersigned by telephone at 709-729-7010 or by email at MichaelCook@gov.nl.ca.

Sincerely,

Michael Cook
ATIPP Coordinator
/Enclosures
Access or correction complaint

42. (1) A person who makes a request under this Act for access to a record or for correction of personal information may file a complaint with the commissioner respecting a decision, act or failure to act of the head of the public body that relates to the request.

(2) A complaint under subsection (1) shall be filed in writing not later than 15 business days

(a) after the applicant is notified of the decision of the head of the public body, or the date of the act or failure to act; or

(b) after the date the head of the public body is considered to have refused the request under subsection 16 (2).

(3) A third party informed under section 19 of a decision of the head of a public body to grant access to a record or part of a record in response to a request may file a complaint with the commissioner respecting that decision.

(4) A complaint under subsection (3) shall be filed in writing not later than 15 business days after the third party is informed of the decision of the head of the public body.

(5) The commissioner may allow a longer time period for the filing of a complaint under this section.

(6) A person or third party who has appealed directly to the Trial Division under subsection 52 (1) or 53 (1) shall not file a complaint with the commissioner.

(7) The commissioner shall refuse to investigate a complaint where an appeal has been commenced in the Trial Division.

(8) A complaint shall not be filed under this section with respect to

(a) a request that is disregarded under section 21 ;

(b) a decision respecting an extension of time under section 23 ;

(c) a variation of a procedure under section 24 ; or

(d) an estimate of costs or a decision not to waive a cost under section 26 .

(9) The commissioner shall provide a copy of the complaint to the head of the public body concerned.
Direct appeal to Trial Division by an applicant

52. (1) Where an applicant has made a request to a public body for access to a record or correction of personal information and has not filed a complaint with the commissioner under section 42, the applicant may appeal the decision, act or failure to act of the head of the public body that relates to the request directly to the Trial Division.

(2) An appeal shall be commenced under subsection (1) not later than 15 business days

(a) after the applicant is notified of the decision of the head of the public body, or the date of the act or failure to act; or

(b) after the date the head of the public body is considered to have refused the request under subsection 16 (2).

(3) Where an applicant has filed a complaint with the commissioner under section 42 and the commissioner has refused to investigate the complaint, the applicant may commence an appeal in the Trial Division of the decision, act or failure to act of the head of the public body that relates to the request for access to a record or for correction of personal information.

(4) An appeal shall be commenced under subsection (3) not later than 15 business days after the applicant is notified of the commissioner’s refusal under subsection 45 (2).
Decision Note  
Department of Health and Community Services  

Title: Improving Oversight of Self-Managed Care  

Decision/Direction Required:  
- Whether to accept the Deloitte report "Improving Oversight of Self-Managed Care" and to begin implementation of the recommendations including identifying a vendor for the development and deployment of a single provincial cloud based platform to provide oversight to both self-managed care and agency based care. 

Background and Current Status:  
- The Provincial Home Support Program (PHSP) Review completed by Deloitte in 2016, found that monitoring and oversight of the program was lacking, and oversight for Self-Managed Care (SMC) was largely limited to financial management. The 2016 review also noted there is a lack of information about client outcomes and effectiveness of the PHSP. 

- The PHSP Review completed by Deloitte in 2016, outlined 25 recommendations to improve the program. A key opportunity, specific to SMC is "Streamline the administration of SMC arrangements to improve accessibility, client choice and RHA monitoring of funding agreements". To achieve this recommendation, a service delivery design for SMC that increases clinical and administrative accountability is required. 

- Self-Managed Care (SMC) is a service delivery option within the Provincial Home Support Program (PHSP) where clients hire their own Home Support Worker (HSW) and are responsible for coordinating and managing their support services. 

- SMC is recognized as an important option within the PHSP as it supports client's choice and flexibility, and increases access to supports for clients living in rural and isolated communities where access to agency based care may be limited or non-existent. Approximately 40% of clients receiving supports through the PHSP use the SMC option. 

- Another opportunity arising from the 2016 PHSP review is the development and implementation of service level agreements (SLAs) between the regional health authorities (RHAs) and home support agencies (HSAs). The review identified that SLAs could emphasize quality improvement, improve clinical oversight and increase accountability (BN-2017-00490 refers). 

- HCS has developed a draft SLA, outlined within is the requirement for HSAs, within a reasonable timeframe agreed upon by both parties, to implement new information systems and technology for clinical and administrative functions.
To begin the process of identifying and implementing new information systems for HSAs, HCS engaged support from the Newfoundland and Labrador Centre for Health Information (NLCHI) to identify the business requirements for an electronic clinical and administrative system that HSAs would be required to implement. The intent was to follow a similar model used for community pharmacies joining the Pharmacy Network, where Government provided the business requirements and pharmacies purchased (in a cost sharing arrangement) a system compatible with the identified specifications.

To meet the PHSP Review recommendation on SMC and in light of the fact that there is limited information available related to monitoring of SMC, Deloitte was engaged to complete further analysis to identify options to improve oversight of SMC. Specifically the objectives of the additional review included:

- Identify oversight and monitoring requirements for SMC option;
- Review accountability mechanisms in other jurisdictions and determine adaptability to and suitability to the NL context;
- Provide recommendations to improve SMC oversight and accountability; and,
- Provide guidance on how these recommendations could be operationalized.

To inform the work, Deloitte established a Steering Committee comprised of representatives from HCS, Western Health and Labrador Grenfell Health. A number of stakeholders were consulted and research on practices in other jurisdictions, both nationally and internationally, was completed. The report Improving Oversight of Self-Managed Care is attached as Annex A.

Through stakeholder consultations Deloitte identified that the following elements are ideally required to improve the ability of the RHAs to monitor all aspects of the SMC option of the PHSP:

- Verification of compliance with legislative and regulatory requirements for operating as a small business;
- Electronic verification of actual hours of care delivered relative to approved services and funding arrangements;
- Verification of required Home Support Worker (HSW) competencies and qualifications;
- Tracking performance indicators such as missed visits, refused service requests, HSW turnover, incidents and complaints; and
- Mechanism for managing service and funding agreements and an auditable record of client payments.

In addition, Deloitte noted that any solutions to improve oversight must reduce administrative burden, improve the user experience, be robust and relatively easy to implement, and minimize upfront and on-going costs.

The report noted that other jurisdictions in Canada are faced with similar concerns regarding accountability and most are attempting to address through policy development that relies on self-reporting of information. In light of the issues outlined in the PHSP review, HCS seeks a more robust mechanism for oversight of both agency based care and SMC.
• Electronic visit verification systems that track time, location and type of service delivered to clients are used in Canada and in the US in agency-based home care services, and some home support agencies (HAS) in NL have already implemented these systems. However, Deloitte noted in the report that the use of oversight enabling technology in other Canadian jurisdictions that use the SMC option is very limited.

• While the report noted that there are many models, a number of US states have chosen to mandate a single vendor within their jurisdictions, to promote standardization and minimize administrative burden on the agency delivering home care services and the public bodies responsible for overseeing the programs.

• The report *Improving Oversight of Self-Managed Care* recommended that HCS:
  o Work with NLCHI to design and deploy a scalable and integrated cloud-based home health care Software as a Solution (SaaS) platform, modified to meet SMC oversight and monitoring requirements;
  o Establish a single, standardized platform across agency based care and SMC service delivery options;
  o Assume shared responsibility for designing and funding a single system recognizing the benefits of improved oversight and administrative efficiencies; and,
  o Continue to implement policy and process improvements in SMC programming.

• Under a cloud based SaaS model approach, a cloud-hosted application with defined features is licensed on a subscription basis. RHA case managers, clients and HSWs, can access the application through web-browsers and mobile devices.

• To implement and operationalize this approach, it is recommended that HCS, the RHAs and NLCHI:
  o Gain hands-on experience with the functionality of home health care technology solutions by soliciting multiple vendor demonstrations;
  o Engage stakeholders including clients, HSA, HSW, and caregivers, to further refine the business requirements for both agency based care and SMC;
  o Undertake a competitive procurement process to select a strategic partner with the technology and organizational capabilities to provide a cloud-based solution under a SaaS licensing model for both agency based care and SMC with the potential to include other community-based programs and services;
  o Use an agile approach to solution development and implementation including rapid development via a co-design approach beginning with SMC in phase 1 and agency based care in phase 2; and,
  o Identify the preferred technology licensing model.

• Deloitte has advised it is extremely challenging to provide a cost estimate to design, implement, and sustain a technology solution for SMC due to the following factors:
  o The business requirements are not fully defined;
  o The level of effort to develop a “fit for purpose” solution is unknown;
  o The level of vendor interest is unknown; and,
  o The type of licensing model is unknown.
• While it is difficult to estimate a cost, Deloitte did provide a broad, conservative estimate to help HCS in decision making and budgeting. Deloitte indicated that the cost to implement a solution for SMC is in the range of $0.75-1.5M and deployment of a universal platform for both SMC and agency based care is estimated at $3.0-4.5M. In addition, application support and maintenance costs are typically between 20%-35% of the initial implementation costs (could be $1.5M annually). These cost estimates could vary significantly depending on the licensing model used.

• For other initiatives such as the Pharmacy Network and the Electronic Medical Record (EMR), HCS has supported private providers (pharmacists and physicians) in cost sharing models to support implementation of these electronic systems.
  o For implementation of the Pharmacy Network, Government funded the full cost of the “core system” including software, infrastructure, integration with other Provincial systems, and provided up to $8,000 per pharmacy to support in-store upgrades. Retail pharmacies covered the costs associated with upgrading their existing in-store systems so they could integrate with the provincial system, and staff training. NLCHI advised that community pharmacies indicated the costs incurred by pharmacies ranged from $5,000-$15,000, although it should be noted that this has not been verified. In this model, business requirements were provided and retail pharmacies could select a product that met the specifications.
  o With the Electronic Medical Record (EMR), the funding arrangement is 70% province funded, 30% physician funded. Physicians are responsible for all in-clinic infrastructure costs (computers, setup of clinic network, staff training) and physicians pay $200/month each to be part of the program.

• The procurement approach outlined by Deloitte represents a non-traditional, but fair, open and transparent approach to vendor selection. Deloitte recommends a competitive two-stage Request for Supplier Qualification (can also be considered an Expression of Interest) procurement approach that includes the following stages:
  o **Stage 1: Written submission** - An open call can be issued for vendors to briefly demonstrate their ability to deliver a solution against established selection criteria which may include:
    ▪ Deliver the business and clinical functionalities required;
    ▪ Ability to implement wide scale software solutions;
    ▪ Ability to develop a solution that can be used in areas with low/no connectivity; and,
    ▪ Deliver a solution compliant with privacy legislation.
  o **Stage 2: Live Demonstration** - Short listed vendors will be invited to demonstrate their solution in collaboration with relevant stakeholders.

• Vendors identified as qualified to deliver the solution will be invited to participate in a “Procurement by Co-Design” process. This model of competitive procurement allows stakeholders to participate in development of the solution and provides an opportunity to assess the capacity of the vendor to create the solution and the nature of future working relationships including the flexibility of the vendor in creating a solution that meets customer demand.
• A Procurement-by-Co-Design approach is more suitable given that there is no product available that meets HCS needs and vendors would be able to demonstrate how they can modify their existing software to meet NL context.

Analysis:
• Development and implementation of an electronic solution for both agency based care and SMC will improve the ability of the RHA to monitor the program, improve clinical outcomes and reduce administrative burden such that clinicians will have more time to do clinical work. In the report Deloitte noted that HCS could develop and implement policies to increase monitoring of SMC and agency based care, however this would be administratively onerous and would likely require increased investments in human resources and may not provide the robust accountability that HCS seeks for the PHSP.

• Implementation of a single system could facilitate integration to other existing or future electronic systems. Procurement of a single electronic system will enable HCS and the RHAs to collaborate with a single vendor, in addition, there may be potential for improved pricing if potential vendors can access a larger share of the market.

• Allowing for HSAs to select their model(s) based on identified business requirements would mean electronic systems in the RHAs would be required to connect with multiple systems.

• Deloitte is recommending a phased implementation to allow time to work through issues with the RHAs in phase 1 prior to full engagement of HSAs in phase 2. This will also allow HCS to identify and address any issues associated with engaging agencies including a better determination of cost estimates, and consideration of any regulatory and service level requirements. Phasing implementation to begin with the SMC option demonstrates HCS’s commitment to equitable oversight of all service delivery options within the PHSP.

• As Government would benefit most from a single electronic system, Deloitte is recommending that Government partially fund or cost share any new electronic system. Further analysis is required to determine potential cost sharing models for the deployment of an electronic solution for HS service delivery. Agencies could cost share infrastructure costs, pay a monthly fee to gain access to the system and to support ongoing maintenance costs or some combination thereof. In addition, consideration may have to be given to the size of the business or the number of clients receiving services in determining costs. Anticipated savings arising from efficiencies realized through implementation of the opportunities in the PHSP review (Deloitte, 2016) can be used to fund this initiative.

• Complete cost sharing by Government is not recommended as the electronic system will likely have business functionalities that are advantageous to HSAs and can be considered part of the cost of doing business. Cost sharing with HSAs helps ensure that Government is engaging with providers who have the capacity to operate a viable business and are interested in increasing quality of the program. At the same time, Government would bear the full cost of developing and implementing a solution for the SMC option of the program. Funding to support this initiative is available from Budget 2016-17 which provided $3.4M in annualized funding to implement opportunities arising from the PHSP review and savings realized from
efficiencies in the HS Program. The procurement approach recommended by Deloitte allows for phased funding requirements.

- Deloitte has recommended an agile procurement approach as there is no “off the shelf” solution readily available. As noted above there is very little activity in the area of monitoring SMC, although Auditor General reports from several provinces have identified the same issues as in this province. Other provinces are also looking for solutions to increase monitoring and accountability of their home care sectors. If the recommendations outlined in the Deloitte report are implemented, NL will be considered a leader in this area.

- According to Deloitte, SaaS has emerged as an option in the home health sector. In this model, the software is licensed on a subscription basis and is not purchased. There are a number of advantages with this approach including:
  - System maintenance and security are the responsibility of the technology vendor;
  - Significantly less expensive in terms of upfront cost and development fees could be amortized through subscription fees which could be negotiated depending on usage;
  - Easier to modify and add to the platform; and,
  - May be easier to discontinue service with the vendor if service level agreements aren’t met given that fees are subscription based and there is no large capital investment.

- NLCHI has experience in engaging with private partners including pharmacists (Pharmacy Network) and physicians (EMR) to deploy software solutions (EMR is a cloud based system). NLCHI is poised to lead development and deployment of this solution and can inform on the technology requirements, integration with existing IT systems, privacy requirements, and procurement and licensing models.

- Further consultation is required with the Public Procurement Agency (PPA) to ensure that the approach proposed by Deloitte meets PPA requirements outlined in the recently released Public Procurement Act.

- During development of the SLA, HCS has communicated to the HSAs that electronic verification systems will be required but that no decisions had been made. HSAs have expressed concern about the costs of new initiatives and have requested an increase to the hourly rate. HCS has repeatedly advised that it will work with the sector to implement specific initiatives within a reasonable amount of time and that there could be opportunities for cost sharing or funding to support some initiatives. The wording of the SLA reflects this commitment. Implementation of the SLA was delayed pending a discussion of concerns with Home Care Association Executive members, which has since occurred allowing implementation to proceed.

- Despite frequent communication that no final decisions had been made regarding electronic verification systems, some HS agencies chose to purchase a system. HCS frequently communicated that there is currently no requirement to have electronic verification systems and that analysis of these systems is under review and no decisions had been made. Further, HCS advised that if agencies were purchasing these systems, it was recommended that
agencies structure contracts to have the ability to discontinue the service if the system and/or business requirements selected by HCS were not compatible.

- It is recommended that HCS accept the recommendations outlined in the report and deploy a provincial electronic system that will improve oversight of home support service delivery for clients availing of agency based care or SMC. It is also recommended that HCS in collaboration with NLCHI and PPA adopt a procurement and licensing approach as outlined by Deloitte. Once a vendor is identified, HCS will seek further approval when cost analysis is developed.

Alternatives:

**Alternative 1:** Accept the recommendations in the Deloitte report including development and deployment of a single provincial cloud based platform designed through a SaaS approach to provide oversight to both agency based care and SMC. [s. 29(1)(a)]

Specifically:
- Work with NLCHI and PPA to develop and issue a RFSQ;
- Engage in development of a product;
- Further refine costs and cost sharing options with the HS agencies; and,
- Seek approval for awarding of contract with a vendor and associated funding.

**Pros:**
- Improves the RHA’s ability to oversee both agency based and SMC options within the program and monitor client outcomes.
- Improves financial management of the program thereby reducing billing errors.
- A single electronic system improves efficiency and ensures RHA staff who manage both options within the HSP have a single electronic solution to learn and manage.
- A single solution will be easier for integration to existing and future electronic systems.
- Vendor interest may be greater if there is a larger market share available.
- A larger market share may drive competition and result in better pricing.
- Partial funding or cost sharing by Government provides an opportunity for Government to maintain control of the system, ensuring a single system is implemented; to be funded in whole or part by savings to be achieved through compliance of actual hours used versus budgeted.
- SaaS licensing model offers less upfront costs.
- Demonstrates to HSAs that opportunities to improve SMC will also be implemented.
- Demonstrates Government is implementing recommendations outlined in the PHSP review.

**Cons:**
- Some HSAs have already purchased electronic systems, if the new software system is not compatible, some HSAs may have to change their systems to be compliant with the SLA.
- Funding will be required.
- Expect self-managed clients and their HSW to raise concerns about use of technology in their homes/monitoring of compliance.
Expect criticism of current bookkeepers whose services may be reduced and/or no longer required depending on how new system results in improved financial management/payroll payment practices.

Alternative 2: Do not accept the recommendations in the Deloitte report and identify separate mechanisms (policy and audit) to improve monitoring and oversight for both agency based care and SMC.

Pros:
- Potentially less funding will be required.

Cons:
- Does not adequately address the opportunity outlined in the PHSP review related to oversight and monitoring of the program.
- Does not support efforts to improve clinical and administrative efficiencies and reduce billing errors.
- Lack of monitoring of clinical outcomes will continue.
- If a software solution is only implemented for HSAs, there may be a different level of monitoring for the two service options which may be viewed as inequitable.

Alternative 3: Do not implement any changes to increase oversight and accountability of SMC option (Status Quo)

Pros:
- No funding will be required.

Cons:
- Does not address the opportunity outlined in the PHSP review related to oversight and monitoring of the program.
- Does not support efforts to improve clinical and administrative efficiencies and reduce billing errors.
- Lack of monitoring of clinical outcomes will continue.
- If a software solution is only implemented for HSAs, there may be a different level of monitoring for the two service options which may be viewed as inequitable.
- Missed opportunity to achieve cost-savings through improved compliance.

Prepared/Approved by: D. Waddleton/A. Bridgeman/H. Hanrahan/J. Abbott
Ministerial Approval: Received from Hon. John Haggie, MD

May 7, 2018
Annex A: 

s. 22(1)(b)