RNAO

Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

THREE YEAR PLAN

ECCO

ENHANCING COMMUNITY CARE FOR ONTARIANS

ECCO 2.0

APRIL 2014

Table of Contents

Dear Colleagues:

In October 2012, the Registered Nurses' Association of Ontario (RNAO) issued *Enhancing Community Care for Ontarians (ECCO)*, a bold model for health system transformation. Subject to significant praise, debate and discussion, this model generated timely and important dialogue on how to make the system more integrated and person-centred, while ensuring the ongoing sustainability of a publicly-funded and not-for-profit delivery model.[1] Today, more than ever, we believe the dialogue must continue in a transparent way that is open to the public. To this end, RNAO is issuing ECCO 2.0.

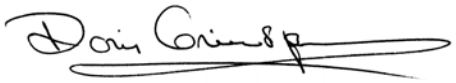
Ontario continues to operate within a context that demands substantive health system transformation to meet the ongoing and future care requirements of Ontarians. This context does not involve 'fixing' or 'tinkering', but a reinvention in how care is organized and delivered, while adhering to the values of Canadians expressed through the *Canada Health Act*. RNAO strongly believes that ECCO provides a robust evidence-based solution for government that will maximize health outcomes and system effectiveness. As Registered Nurses, we have a duty to ensure that the system is designed to meet the needs of people and not politics.

Prior to releasing ECCO in 2012, RNAO engaged in robust dialogue and consultation that served as the foundation to develop the ECCO model. Release of the white paper has bred a new layer of consultation and discussion through countless webinars, teleconferences, meetings, presentations and personal engagement with members and stakeholders. This process has guided RNAO in developing ECCO 2.0, the next phase of the white paper, which adds greater depth and dimension to the ideas and principles first introduced in October 2012.

The document that follows clarifies and expands our positions. To be clear, RNAO's positions have not changed since the initial 2012 release of the ECCO model. Through the leadership of a bold and visionary Board of Directors, we remain steadfast in our commitment towards embracing the potential that exists within the system. We are not withdrawing any of the ideas previously expressed, however, we are adding to them from the rich dialogue that has occurred.

Moving forward, RNAO invites continued dialogue, discussion and debate regarding the ECCO model. Moreover, we encourage a provincial discussion regarding the future directions of our health system where Ontarians represent the leading voice influencing this change.

In closing, RNAO extends its gratitude to the many people and organizations that have influenced the development and expansion of ECCO and we are looking forward to its continued evolution.



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ECCO: Enhancing Community Care for Ontarians – A Three Year Plan

White Paper – V 2.0

Executive Summary

In 2012, Ontario's nurses issued *Enhancing Community Care for Ontarians* (ECCO), a call on government and stakeholders to collectively strengthen our publicly-funded, not-for-profit health system and make it more responsive to the public's needs, easier to navigate, more efficient and cost-effective. We argued then, and continue to argue in ECCO 2.0, that truly transforming the system demands advancing primary health care for all through: health promotion, disease prevention, social and environmental determinants of health and community care. Equally important are changes that enable nurses and all other regulated health professionals to work to their full scope of practice, a commitment to reducing structural duplication, and advancing system integration and alignment.

Ontario's *Action Plan for Health Care* supports a continued shift of care delivery to the home and community settings to improve patient outcomes and system cost-effectiveness.[2] However, the ability of government to achieve a robust community care sector and health system cost-effectiveness is seriously hampered by existing duplication and excess structure.

Today, much of Ontario's community care services continue to be organized by 14 Community Care Access Centres (CCAC) that utilize roughly $ 2.2 billion of public resources each year.[3] In 2008/09, 9 per cent, or $163M, of total funding was expensed by CCACs in operational and administrative costs,[4] demonstrating significant growth in administrative budgets that outpace growth in direct care dollars. In 2012/13, the most recent year for which CCACs have finalized data, CCAC administration costs were 8.7 per cent, or $191.4M, of their total funding of approximately $2.2 billion.[5] A breakdown of these administrative costs includes: 4.4 per cent for general administrative costs, 2.0 per cent for facilities/other and 2.3 per cent invested in information technology.[6] Questioning the necessity for such an administrative infrastructure is critical at a time of tightened government treasury, and especially important given the duplication and role conflict that continues to exist between CCACs, primary care, hospitals, home health-care providers, support service providers, and Local Health Integration Networks (LHINs).

Given the growing maturity of LHINs and the primary care sector, the time has come to fully advance health system integration and eliminate unnecessary duplication, by enabling LHINs to oversee whole system regional planning, funding and accountability functions. To achieve this aim, the legislation governing LHINs (*Local Health System Integration Act*) -- now under review -- must be amended to include all sectors within the LHIN's mandate, including public health units, all of primary care and home health-care organizations. Encompassing all sectors within the LHIN mandate will advance co-ordination and integration of service to more effectively meet the needs of people. Moreover, opportunity exists to phase out the presence of CCACs over the next two years by transitioning their functions into existing structures within the health system. These objectives, combined with the need to advance primary health care and population needs-based planning, form the ECCO model, which was first released by

RNAO in October 2012. Using the analogy of an eco-system, RNAO created a responsive model that is meant to reflect the realities and interactions between people and their communities, within the context of primary health care. The model does not propose a one-size-fits-all approach to community care; rather it provides a conceptual template that can be localized within the specific geographical and community context where it is applied.

ECCO proposes that interprofessional primary care organizations such as Community Health Centres (CHC), Nurse Practitioner-led clinics (NPLC), Aboriginal Health Access Centres (AHAC) and Family Health Teams (FHT), expand their reach and role over the next two years, with the support of a temporary LHIN-led 'Primary Care Transitional Secretariat'. This Secretariat can be tasked with organizing local geographic primary care networks, encompassing all primary care models, to improve sector capacity on an interim basis until current interprofessional models are sufficiently expanded. ECCO, proposes that interprofessional primary care organizations provide complete care co-ordination and health system navigation for all Ontarians by 2015, including the referral for home health-care and support services, thus eliminating the need for CCACs. Current registered nurse (RN) care co-ordinators working within CCACs, would transition to the primary care setting and contribute their expertise and system knowledge by providing dedicated care co-ordination and health system navigation to Ontarians with the most complex needs. The remaining population, with varying degrees of complexity across the lifespan, will receive care co-ordination from the existing primary care RNs and non-RN care co-ordinators which transition from CCACs to primary care.

The ECCO model maintains the current salary and benefits of CCAC care co-ordinators, using the current funding envelope available, as direct employees of primary care organizations. The model strengthens the ability of these professionals to effectively lead care co-ordination and system navigation across the care continuum, with an intense knowledge of their clients from "womb to tomb", without being burdened by the overwhelming administrative tasks that are a foundation of their current role in CCACs. The ECCO model assumes expertise of home health-care and support service providers, and their individual and collective commitment to clients and the health system. The model leverages these strengths to empower a greater sense of professional autonomy in the planning and delivery of service to Ontarians, ensuring optimal client/family/provider engagement, service satisfaction, and provider accountability.

This white paper presents a model that advances a robust foundation for a renewed person-centred health system that emphasizes community care and improves integration across all sectors through a single health system planner and funder – the LHINs.[7] ECCO begins with service and process enhancements by creating primary care networks, and transitioning the care co-ordination role function from CCACs to primary care, including the 3,500 care co-ordinator positions. ECCO is completed with the alignment of public health services with the LHINs, formation of local primary care networks, transitioning responsibility for home care services directly to home care agencies, devolving accountability for whole system planning and related functions to a single infrastructure -- the LHINs -- and eliminating the CCAC as a system entity. This paper provides an overview of the ECCO model to

inform and evolve strategies that ensure timely access to Ontario's health system, improve client experience and outcomes, and deliver comprehensive services in a cost-effective and seamless manner.

Although the transition of CCACs does not increase the global supply of available resources, it enhances the position of funding to improve outcomes for people and the health system. The more effective use of funding involves relocating 3,500 care co-ordinators to work within primary care, thus creating a more robust primary care system; and reinvesting -- as a starting point -- over $191M of current CCAC administrative costs into home health-care and support service organizations to increase the number of hours of direct care delivery.

What Has Changed Since Initial Release In October 2012?

The core foundations and positions of the ECCO model have not changed. Government and other stakeholders have had ample time to implement the model. Therefore, the timelines included in 'Table One' have not been significantly altered. ECCO is now an overdue solution for Ontario's health system.

More details have been included in the document based on considerable engagement and consultation. A summary of additional changes can be found below:

- Context and background updated;
- CCAC operations and outcomes continuously analyzed;
- Labour management strategy included (through the generous pro-bono support of Fasken Martineau);
- Public health considerations expanded;
- Cross-analysis between 'Health Links' and ECCO included and
- Long-term care section expanded to include 'Rehabilitation, Complex Continuing and Residential Care'.

Introduction

There is an urgent need to shift the focus of our health system towards advancing health promotion and substantively strengthening community care. Just imagine the benefit on people, the health system and governments' budgets - if we can prevent and/or delay the onset of chronic diseases and their complications.

The need to accelerate this agenda is further heightened by a lingering recession and compounded by Prime Minister Stephen Harper's decision to distance his government from renewing a Health Accord. The Accord, which expired in March of 2014, will see health transfer payments reduced from an annual six percent to a likely three to three and a half percent a year by 2018. The Ontario Hospital Association (OHA) reports "… there are plans for real-dollar cuts to the health budget but no apparent strategy for change that incorporates all sectors of the system that is synchronized with budget financial goals and timelines."[8] RNAO agrees: Ontario's fiscal reality, in the absence of all political parties refusal to explore increases in taxation, demands a hard look at policy and funding imperatives for our health system.

Some health-care and political leaders will be tempted to choose the road of privatization using the old mantra of "we can't afford a universal health system anymore" and push their way towards for-profit delivery, user fees, medical tourism, and other forms of privatization. There are those that are already suggesting that we increase the involvement of the private sector in Ontario's community care setting, coupled with user fees and co-payments.[9] RNAO vigorously opposes privatizing our health services, and we warn politicians that such an approach will prove to be a political nightmare -- simply because it delivers less quality at higher costs.[10,11,12] The second approach, and the one supported by nurses, is to transform the system by strengthening our publicly-funded, not-for-profit health system, advancing primary health care for all and making the health system even more cost-effective through: 1) health promotion, disease prevention and community care; 2) social and environmental determinants of health; 3) full scope of practice utilization; 4) interprofessional and evidence-based care, and 5) reducing structural duplication to advance system integration and alignment[13].

In January 2012, Ontario's Minister of Health and Long-Term Care introduced an *Action Plan for Health Care* to achieve: "Better client care through better value from our health care dollars."[14] The plan identifies that the province's population structure is changing, care requirements are becoming increasingly complex and without action, the strain placed on the health system and public purse could challenge the sustainability of Ontario's health system.[15] This plan proposes a continued shift of care towards the community, a move supported by studies that show that clients prefer to receive care at home and experience comparable or better outcomes than when cared for in institutional settings.[16,17,18,19,20] Studies also show that receiving care at home is considerably less expensive for the health system.[21,22] It is estimated that caring for seniors at home costs 67 per cent less than care provided in a long-term care home and 95 per cent less than care provided in a hospital.[23] However, despite the public's strong preference for non-institutionalized care and its cost-effectiveness, only six per cent of Ontario's health budget is dedicated towards the community, while 34.7 per cent is dedicated to hospitals and 7.7 per cent to long-term care homes.[24]

Provincial and territorial governments, through the "Council of the Federation" (COF), launched a Health Care Innovation Working Group as a means of working together to improve capacity to meet future health system challenges.[25] In July, 2012, COF reported significant progress on expanding team-based approaches to primary care, managing health human resource costs, and adopting clinical practice guidelines (CPGs).[26] The Registered Nurses' Association of Ontario (RNAO) was central to the initiative, actively participating as an expert and proud member of the CPG working group, alongside the Canadian Nurses Association (CNA) and Canadian Medical Association (CMA).

The present context provides the platform for RNAO's perspectives on the necessary structural and funding changes to advance health system transformation; all of which were introduced in the *Enhancing Community Care for Ontarians (ECCO)* model first launched in October 2012. Using the analogy of an eco-system, RNAO's model reflects the realities and interactions between people and their communities within the context of primary health care. The model does not propose a one-size-fits-all approach to community care; rather it provides a conceptual person-centred template that can be localized within the specific geographical and community context in which it is applied. As important, a key goal of this work is to stimulate a ripple or 'echo' effect across all sectors of the health system to improve system connectivity and effectiveness, and the resulting client experience and outcomes. ECCO is more than a structural change. The model starts with enhancements to both system process and service delivery. These enhancements will then lead to structural changes that will decrease disruptive duplication, and improve system integration, health outcomes and system effectiveness.[27]

As the professional association representing registered nurses (RNs) working in all roles and sectors in Ontario, RNAO believes it has a duty to shape the province's health system in a way that strengthens its universality and will best serve Ontarians today and tomorrow. Simply put, the ECCO model leverages the strengths of Ontario's health system and addresses areas of challenge where there is unnecessary duplication and inefficiencies. To achieve this, RNAO proposes a two year transition where the person (i.e., patient/client/resident) is placed at the centre of the health system; primary care anchors the system; and the LHINs are regionally accountable for whole system planning, funding allocation, monitoring and evaluation. ECCO's health system transformation also entails that the functions of the Community Care Access Centres (CCACs) are transferred to strengthened areas of the health system, leaving behind unnecessary and costly layers of administration. Specifically, the care co-ordination function and the CCAC care co-ordinators are transferred to primary care; clinical services are re-allocated to home health-care organizations and public health units (palliative care NPs, rapid response nurses and mental health nurses in schools); and all functions related to funding allocation/service agreements/monitoring and evaluation are transferred to the LHINs. The process RNAO used to develop the ECCO model was grounded in evidence (Appendix A) and involved broad consultation with a number of individual experts and expert organizations (Appendix B).

Drivers for Change

Ontario, like most jurisdictions in the world, is experiencing a rapidly growing and aging population. Approximately 10 per cent of the population accounts for 80 per cent of health spending.[28] While consensus has not been reached on the composition of this population-segment, it likely includes a portion of older adults living with multiple co-morbidities; persons with complex mental health and addictions challenges; and other vulnerable populations. Experts predict that between 2009 and 2036, the proportion of Ontarians over age 65 will double from 13.7 per cent of the population share to 23.4 per cent respectively.[29] In his report, *Living Longer, Living Well,* Dr. Samir Sinha identifies that in Ontario, older adults "…while accounting for only 14.6 per cent of our current population, nearly half of our health care spending occurs on their behalf."[30] RNAO has long been on record in proposing that aging in place is imperative, both for older persons and for creating vibrant communities.[31,32,33] However, Canadian jurisdictions have done little to plan for the evolving demographic landscape, largely focusing social and health system policy on illness-based care. Consequently, from a health system planning perspective, little focus has been targeted towards the care of older persons living healthy lives at home, with the aim of preventing, delaying or managing chronic conditions and complications. Moreover, Dr. Sinha identifies a provincial call exists to "recognize our aging population not as a challenge, but rather as an opportunity for Ontario."[34]

Of mutual importance is the need to focus on health status in the early years of life. All too often the exclusive focus of policy-makers has been on care towards the latter stages of life. The Ministry of Children and Youth Services identifies that: "A child's early years from before birth to age six are very important for healthy development. This is a time when a child's brain and body are developing at a rapid pace. Healthy babies and toddlers are more likely to stay healthy through their childhood, teen and adult years."[35] The Provincial Government's Healthy Kids Panel identified that: "Laying the foundation for a lifetime of good health begins even before babies are conceived, and continues through the first months of life. We must provide the support young women need to maintain their own health and start their babies on the path to health."[36] Ensuring health in the early years of life goes beyond the health-care system and requires a broad approach that involves the social determinants of health. Therefore, there is an increased need to focus on the complex needs existing at opposite ends of life, while also ensuring that those in between are enabled to experience optimal health.

Additionally, one in five Canadians, from all backgrounds and walks of life, will have a mental illness or addiction in their lifetime[37,38] and the degree of morbidity experienced will highly vary across this group. The toll that mental illness takes on people and the health system is significant. Moreover, the system is not optimally designed to support the prevention, detection, treatment and recovery of mental health and addictions.

However, it is important to flag that not every older adult with a chronic condition or individual with a mental illness exhaustively taxes health system resources. For example, in 2007, 76 per cent of Canadian seniors over age 65 reported having one or more chronic conditions.[39] However, at the same time 77 per cent of Canada's seniors also reported their health status as being excellent, very good or good.[40] Moreover, one in four Canadian seniors do not report having any chronic conditions at all.[41] Therefore,

the fact that so few consume so much of Ontario's health resources is not the fault of individuals or groups, but the result of a disjointed, institutionally-focused and illness based health system that has done little to support people to thrive as vibrant community members

The solution is clear, Ontario must urgently shift emphasis towards advancing primary health care for all, focusing on optimizing peoples' potential to enjoy fulsome lives in their communities. To achieve this hefty goal, greater attention must be placed on social and environmental determinants of heath to ensure we promote health and prevent illness; tackling mental illness from a young age; and delaying chronic conditions and their complications. Along the way we must build a seamless health system that people can count on in times of health and in times of illness. A health system that is easy to navigate and delivers the best possible outcomes. Ontario's nurses are determined and ready to make this happen.

Nurses fully understand that action must be taken to contain health-care spending, while concurrently creating a health system that is more responsive to the complex and dynamic needs of communities. For this to occur, it is imperative that all health sectors are enabled to maximize their service priorities, while minimizing duplication and administrative burden.

Community Care Access Centres (CCACs) – A Case For Change

CCAC Role

CCACs were developed by former Premier Mike Harris in 1996 to:

- "Bridge between hospital and home
- Provide the extra help clients need to maintain their independence and live safely at home
- Help clients navigate the health-care system
- Support families in making arrangements for long-term care"[42]
- Develop and deliver a competitive bidding process for service procurement

Today, Ontario has 14 CCACs that employ approximately 6,053 people and provide service to about 653,000 Ontarians.[43] The annual budget for CCACs is around $2.2 billion.[44] CCACs receive funding from the Ministry of Health and Long-Term Care (MOHLTC) and Local Health Integration Networks (LHINs) and issue contracts to a mix of for-profit and not-for-profit home health-care and support service providers to offer: nursing, personal support, homemaking, home support, occupational therapy, speech language pathology, physiotherapy, dietetics and social work services.[45] Until 2008, a competitive bidding process was used to procure service contracts that saw providers bidding against one another.[46] Significant concern was raised by many groups, including RNAO, regarding the effectiveness and impact of the competitive bidding process on client care, continuity and health system performance. These concerns have also been validated within the literature.[47,48] Additional concern has been expressed regarding the over emergence of for-profit providers, related to the competitive bidding process, given that research identifies that not-for-profit health services produce more quality client outcomes and higher staffing hours of nursing care.[49,50] While competitive bidding for contracts has not occurred in some time RNs will continue to actively oppose this process and reject any calls for its reemergence

CCAC Structure

The largest component of CCAC staff are care co-ordinators, formerly referred to as case managers, who are described by CCACs as being: "…responsible for client assessment, determination of eligibility, admission, service planning and authorization, implementation, monitoring, reassessment, adjustment and discharge planning of all client service programs (in-home and placement), including the provision of community resource information and referral. Case managers link clients with the right information and help them achieve their short and long-term health-care goals."[51] There are approximately 3,500 interprofessional care co-ordinators employed in CCACs across Ontario, many of whom are nurses, physiotherapists, occupational therapists, speech language pathologists and social workers. [52] The great majority of CCAC care co-ordinators are RNs – about 3,000. Other functions served by CCACs include discharge planning, long-term care home placement and administering programs such as Health Care Connect. [53,54] More recent programs added to CCACs include: Mental Health and Addictions Nurses in District School Boards, Rapid Response Nursing Program and the Nurse Practitioner Integrated Palliative

Home Care Program.[55] The latter programs suggest that the CCACs are taking on a more direct care role, which was not their initially intended purpose. It is questionable whether the CCAC system possesses the mandate or efficient capacity to deliver direct care to Ontarians. Ontario's Senior Strategy Lead, also questions whether this is an appropriate development.[56] Moreover, these newly-created functions of the CCAC are destabilizing the community care workforce, given the inequitable compensation structures that exist across CCACs, primary care organizations and home health-care and support service organizations. CCACs have been equipped with the resources to provide significantly higher wages and benefits, thus impacting recruitment and retention in other areas of the community.

CCACs are increasingly adopting outcome-based clinical pathways that use evidence and bundle-based reimbursement to enable person-centred care.[57] While encouraging, this development advances an identity crisis for CCACs which have largely devoted their efforts towards determining individual service allocation. CCACs are now setting their sights towards a broader-level of health system co-ordination which "[bridges] primary care with the home and community care sector and other parts of the health system through new and/or enhanced partnerships, while ensuring a coordinated patient journey."[58] This creates duplication with the primary care setting, adds an administrative layer to the care co-ordination process and conflicts with the evidence articulating the need to position primary care as the co-ordinating centre of the health system (Appendix A). Ontarians need, want and deserve a seamless care journey. Applying a person-centred care planning perspective, it does not make sense to enable a third party such as the CCAC to co-ordinate care when Ontario's primary care setting is ready and willing to take on this important function. The Association of Ontario Health Centres, has publicly communicated that: "Our association's 73 Community Health Centres, 10 Aboriginal Health Access Centres, four Nurse-Practitioner- led clinics and 15 Community Health Teams look forward to actively supporting the transition from Community Care Access Centres to primary health care."[59]

It is critical to flag that the shortcomings of the CCAC system are **not** the fault of the many health-care professionals that are employed within the model. These expert professionals play a tremendously valuable role in the health system and need to be better supported to produce the outcomes they so desperately wish to achieve with their clients. The ECCO model situates primary care as the most effective setting to deliver care co-ordination services, and transitions the care co-ordinators to primary care.

CCAC Performance

Use of Funding

CCACs are structured in a manner that challenges their ability to adequately and efficiently fulfill their functions. Findings from a 2010 report of the Auditor General of Ontario identified inequities in how care is provided to Ontarians, inequities in the level of service being provided, inequities in how CCACs are funded, wait-lists in 11 CCACs totaling approximately 10,000 people, delays providing initial client-care assessments and absence of quality monitoring to improve performance at the provider and CCAC level.[60] Of particular concern is that the Auditor General initially identified many of these concerns as early as 1998 and they still have not been addressed.[61] Some may argue that these concerns are not the

fault of the CCACs themselves, but of LHINs and the MOHLTC as CCAC funders. However, it is important to note that the MOHLTC has increased CCAC funding by 56 per cent since 2003/04 and has made significant investments, such as the Aging At Home Strategy, to support seniors and others living independently at home. [62] As part of its 2013 Budget, the provincial government committed to increasing funding for home and community care by $260 million in 2013-14.[63] Despite ongoing funding increases, the media is filled with concerning reports about Ontarians' difficulty accessing home health care and support services.[64] The voice of the public challenges any belief that the current system is optimally structured to co-ordinate care and arrange home health-care and support services.

In 2008/09, 9 per cent, or $163M, of total funding was expensed by CCACs in operational and administrative costs,[65] demonstrating significant growth in administrative budgets that outpace growth in direct care dollars. In 2012/13, the most recent year for which CCACs have finalized data, CCAC administration costs were 8.7 per cent, or $191.4M, of their total funding of approximately $2.2 billion.[66] A breakdown of these administrative costs includes: 4.4 per cent for general administrative costs, 2.0 per cent for facilities/other and 2.3 per cent invested in information technology.[67] In comparison, the Minister of Health and Long-Term Care directly reports that the LHINs perform planning, accountability and administrative functions within 0.3 per-cent of their budget.[68] An analysis conducted by the Hamilton Spectator identified that in 2010, the total administrative expenditures for the operation of 14 LHINs was $68M.[69] It is important to note that this figure is less than half of that used by CCACs on administration two years earlier. Moreover, through an analysis of annual salary disclosure data that is publicly reported, 299 senior CCAC staff reported incomes over $100K totaling approximately $37.4M in salary costs in 2013.[70] This is an increase of 71 staff and $8.4M since 2011 – despite the government's wage freeze. In early 2014 a flurry of public concerns emerged in the media regarding the compensation of senior management within CCACs, including a "144 per cent pay increase" for the CEO of the South West CCAC over six years.[71,72] To clarify, the South West CCAC was formed in 2007 as an amalgamated organization. An analysis of public sector salary disclosure documents indicates that over six years between 2007-13, the CEO's salary increased by approximately 60 per cent ($180,034 in 2007 to $288,462.50 in 2013). Furthermore, the CCACs possess extensive capital infrastructure and are increasing administrative expenditures while decreasing client care funding. For example, the Central CCAC reported increased revenues of approximately 3.8 per cent between 2010 and 2011, however, the purchasing of client care decreased by approximately 1.5 per cent.[73] This is not an isolated incident as the Central East CCAC reported a revenue increase of approximately 3.3 per cent between 2010 and 2011, however, the purchasing of client care decreased by approximately 10.6 per cent.[74] Over a three year period, the number of CCAC staff has increased by over 10 per cent.[75] These numbers raise serious doubts as to whether the CCAC model is the most cost efficient way to oversee community care in the province.

In response to the ECCO model, CCACs report their overall administrative spending to be 8.2 per cent, having decreased by 0.4 per cent over four years.[76] This figure is considerably higher than best practice. Moreover, there is increasing inquiry over how this figure is reported.[77] For example, some argue that this figure relates only to the direct operation of the CCAC Corporation and does not take into account the full administrative costs associated with delivering care. These administrative costs are often

inevitable and may involve capital assets, administrative support, business supplies, etc. However, not including them in the total figure of administrative spending may be misleading. Therefore, the actual proportion of administrative spending could be higher than 8.2 per cent. The ECCO model does not challenge whether care co-ordination represents care delivery; RNAO feels that it does and fully embraces the clinical value of care co-ordination services.

Amidst significant public concern, both the Ontario Progressive Conservative (PC) Party and the New Democratic Party of Ontario have called for reviews of the CCAC system. In February 2014, the Ontario PC Party asked the Auditor General of Ontario to conduct a comprehensive review of the CCAC model, while the NDP have called for a legislative review.[78,79 The] Minister of Health and Long-Term Care has indicated that she welcomes the Auditor General to conduct another review of the CCAC model.[80]

Performance and Impact for Ontarians

There are also concerns over whether CCACs are structured to handle increased shifts of care to the community given waitlists to access non-nursing services. The Auditor General found that in 2008/09, 10,000 people were waiting for home care services with an average wait time that ranged from eight to 262 days.[81] The Auditor General also found that in 2009 more than 50,000 hospitalized patients could have been discharged sooner if there were not delays in arranging post-discharge care.[82] In fact, these delays accounted for 16 per cent of total hospitalized days in Ontario's health system.[83] The CCAC structure is limited in its ability to prevent re-admission to hospitals, which taxes precious health system resources. In 2009 there were 140,000 instances where clients were re-admitted to the hospital within 30 days of discharge.[84] While it is not clear what proportion of these hospitalizations were unavoidable, this figure is too high given the potential that Ontario has to deliver community care and keep people well at home. Using figures from the North East LHIN[85], the estimated cost to the health system of these re-admissions was calculated by RNAO to be up to $118M per hospitalized day versus up to $5.8M per day if care was provided at home. This staggering statistic undermines government investments and efforts to avoid costly hospital re-admissions.

CCACs are set up to become involved in a client's care when an event has occurred to prompt action. In 2009/10, approximately 60 per cent of referrals to CCAC were in follow-up to a hospitalization.[86] The CCAC structure is not setup to effectively prevent costly hospitalization. It is also unclear what action is being taken to manage the complex care requirements of vulnerable segments of the population (i.e. persons experiencing homelessness). The end result is a patchwork system that is not co-ordinated or continuous. As the Association of Ontario Health Centres notes: "CCACs are not set up to meet the complex social, cultural and medical needs of clients from birth to death and do not perform the breadth of system navigation with social services, education and other services that are required by socially complex clients."[87] It is neither in the public's interest nor the Ontario government's interest to invest into a system that is failing to meet the needs of its most vulnerable and complex citizens. A co-ordinated and integrated person-centred system is needed to focus on health promotion and other proactive activities, rather than costly institutionalized care.

There are also questions surrounding the transparency of CCACs. There are two striking concerns: a media clause that prevents whistle blowing and the fact that the *Freedom of Information and Protection*

of Privacy Act (FIPPA) does not apply to CCACs. The media clause limits the ability of care providers, contracted by the CCAC, to speak out on emerging issues. The Ontario Association of Community Care Access Centres describes the purpose of the clause as: "… a proactive measure to protect a patient's health information and to avoid the dissemination of inaccurate information that might come from someone who does not have all the facts."[88] It is questionable why CCACs have instituted a media clause as a means of protecting patient privacy given the robust obligations specified in statute through the *Personal Health Information Protection Act.* Preventing providers from speaking out in hopes of preventing the communication of misinformation is a drastic mitigation strategy. This clause also suggests that disconnected systems are in place that prevents the transparent sharing of information, which could lead to misinformation being produced. Lastly, from an accountability perspective, it does not make sense that the CCAC system, which handles over $2 billion dollars worth of public funds, is not subject to FIPPA. The public has the right to receive transparent and accountable information from the CCAC system.

Leadership

On July 13, 2012 it was announced that the Minister of Health and Long-Term Care appointed a supervisor for the Waterloo Wellington CCAC to: "… address leadership, governance and operational issues at the centre."[89] This appointment was based on a recommendation from the Waterloo Wellington LHIN following an organizational review.[90] This review raised significant concerns over leadership and ongoing service restrictions resulting in "on-again/off-again" client care.[91] Given the rising revenue and expenditures allocated to administration within CCACs, it is deeply concerning that a provincially appointed supervisor had to be engaged to provide leadership in the organization.

Each CCAC belongs to a provincially-funded umbrella organization called the Ontario Association of Community Care Access Centres (OACCAC). The OACCAC describes itself as: "Working hand-in-hand with CCACs, [to] deliver high-quality products and services that support and assist [its] members in helping people find their way through Ontario's health-care system. [The OACCAC] also assists [its] members in developing innovative, cost-effective ways to provide people with the care they need when they need it."[92] In reality, the OACCAC operates as a taxpayer funded advocacy group, lobbying the government to advance the self-interests of CCACs.[93] The operating budget of the OACCAC is not publicly reported, however, an analysis of 2013 salary disclosure data identified that approximately $4.7M ($5.6M assuming 20 per cent benefits) is expended annually for the human resource costs of 35 senior staff.[94] The 2013 OACCAC Annual Report identifies an eHealth budget of approximately $20M.[95] Given the significant structural duplication present within the CCAC model, it is questionable whether there is value in retaining the OACCAC or whether the OACCAC simply represents another layer of unnecessary bureaucracy in a saturated health system. It is also important to highlight that the OACCAC is not subject to FIPPA.

In November 2013, the OACCAC released a series of reports entitled: "*Health Comes Home: A Conversation About the Future of Care"* to explore policy ideas regarding the future sustainability of community care.[96] Within these reports, the OACCAC pitches 'opportunities' for increased private sector involvement in the financing of care delivery and floats ideas regarding user-fees, co-payments and

'tiered' systems of care.[97] It is concerning that instead of looking for innovative solutions that keep health care and support services in the public sphere, CCACs, as current system entities, are defaulting to calls for privatization. Ontario's nurses strongly oppose calls for increasing privatization and introducing user-fees and/or co-payments. RNAO has not given up on the potential to maximize a publicly-funded, not-for-profit health system that advances universality and equality. Indeed, the current model of community care delivery is not sustainable. However, RNAO feels that the ECCO model is the solution needed to sustain and enhance community care in Ontario without having to resort to privatized models at the expense of Ontarians.

The Need to Evolve CCACs

The context is ripe to advance a discussion regarding the location of care co-ordination services within the health system. In June 2012, RNAO released a report entitled *Primary Solutions for Primary Care – Maximizing and Expanding the Role of the Primary Care Nurse* as an outcome of the Primary Care Nurse Task Force. [98] In this report, 20 key recommendations are provided that look at the potential that currently exists within the health system to transform primary care delivery in Ontario. It was the unanimous agreement of the interprofessional provincial task force that led the development of this report, that care co-ordination and system navigation must be located in primary care. A working definition of care co-ordination was developed, through the analysis of over 40 definitions within the literature, as: "the deliberate organization of client care activities between two or more participants (including the client) involved in a client's care to facilitate the appropriate delivery of health services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required client care activities, and is often managed by the exchange of information among participants responsible for different aspects of care."[99] An important facet of care co-ordination is health system navigation that can be defined as: "[offering assistance] to clients in "navigating" through the complex health system to overcome barriers in accessing quality care and treatment."[100] *Ontario's Action Plan for Health Care* identifies the need for health system navigation and care co-ordination, especially for seniors and those who are living with multiple chronic health conditions.[101]

Of the 20 cost-effective recommendations in the Primary Care Nurse Task Force report, a key recommendation involves leveraging the competencies, knowledge and skills of primary care RNs to facilitate care co-ordination. Care co-ordination is a shared function of the interprofessional health-care team. However, there is a need for patients to identify a single point of contact within the system as a means of managing transitions and enabling overall navigation and co-ordination. Primary care RNs are the well situated with the educational preparation, clinical knowledge/experience, public trust, awareness of the system and comprehensive understanding of the social determinants of health, to support and co-ordinate the broad preventative and responsive care needs of Ontarians from 'womb to tomb.' From a human resource utilization perspective, it is imperative that available resources be utilized at a cost neutral expense to the health system. There are approximately 6,500 primary care nurses already working in Ontario, of which almost 4,000 are RNs.[102] ECCO proposes that these 4,000 RNs provide care-coordination -- anchored in primary care -- for the great majority of Ontarians. The 3,000 RN that are currently working in CCACs, would transition to primary care and provide care-

coordination and system navigation for the 10 per cent of Ontario's population with complex care needs.

The report of the Commission on the Reform of Ontario's Public Services also questioned the future existence of CCACs and specifically recommended integrating them within the LHINs. Ontario's Senior Strategy discusses the opportunity to improve integration between LHINs and CCACs.[103] In late 2012, the Ministry of Health and Long-Term Care introduced the 'Health Links' initiative to enable greater collaboration across providers through improved co-ordination and information sharing, with an aim of providing more timely care for Ontarians with complex conditions and reducing the likelihood of hospital re-admissions.[104] This initiative is increasingly placing the person at the centre of the health system, anchoring system functions within primary care and integrating CCAC functions directly within primary care organizations.[105] At the same time, the Ontario Government is moving forward with regulation changes under the *Home Care and Community Services Act* to enable support service agencies to directly provide publicly-funded personal support services to specific clients, without involvement of the CCAC.[106] Each of these developments creates a context to analyze the current delivery of community care and to understand how the system can be transformed to expedite improved integration and person-centeredness.

It is clear that a person-centred model must be implemented that enables primary care RNs and other health professionals, to lead care co-ordination and health system navigation, while producing structural changes that advance primary health care, service integration and flow. Such a model must be cost-effective and look to the potential within the health system while eliminating duplication, unnecessary administration and inefficiencies. Quality and care continuity must be at the centre of this model to improve client outcomes, experiences and strengthen the capacity of care providers across the health system. Structural reform must also target improving outcomes for the few who have the greatest need for health services.

ECCO Model

RNAO's model, known as *Enhancing Community Care for Ontarians (ECCO)*, focuses on:

- Advancing primary health care for all by expanding the reach, functions and access to comprehensive interprofessional primary care models, integrating social and environmental determinants of health
- Maximizing and expanding the scope of practice utilization of all regulated health professionals to strengthen Ontario's publicly-funded, not-for-profit health system through timely access and health system cost-effectiveness
- Ensuring person centredness, including clients, families, and caregivers in all planning and decisions
- Emphasizing health promotion, disease prevention, mental health and chronic disease prevention and management
- Improving quality of care and outcomes across the health-care continuum by expecting and supporting evidence-based care
- Leveraging the expertise of public health to inspire community engagement and population health planning
- Developing robust home health-care and support services
- Eliminating structural duplication, and facilitating health services integration
- Focusing expert attention on Ontarians with complex needs that require the greatest proportion of health-care resources
- Improving continuity of care through consistent interactions with providers and the elimination of walk-in clinics/unnecessary emergency department utilization

Over the past 10 years significant government investments have considerably strengthened Ontario's primary care system, while the establishment of LHINs has increased local planning capacity. The ECCO model integrates the current functions and roles of the CCACs into existing structures, organizes primary care entities and stimulates overall system integration and co-ordination through the LHINs.

Figure One – ECCO Model Overview

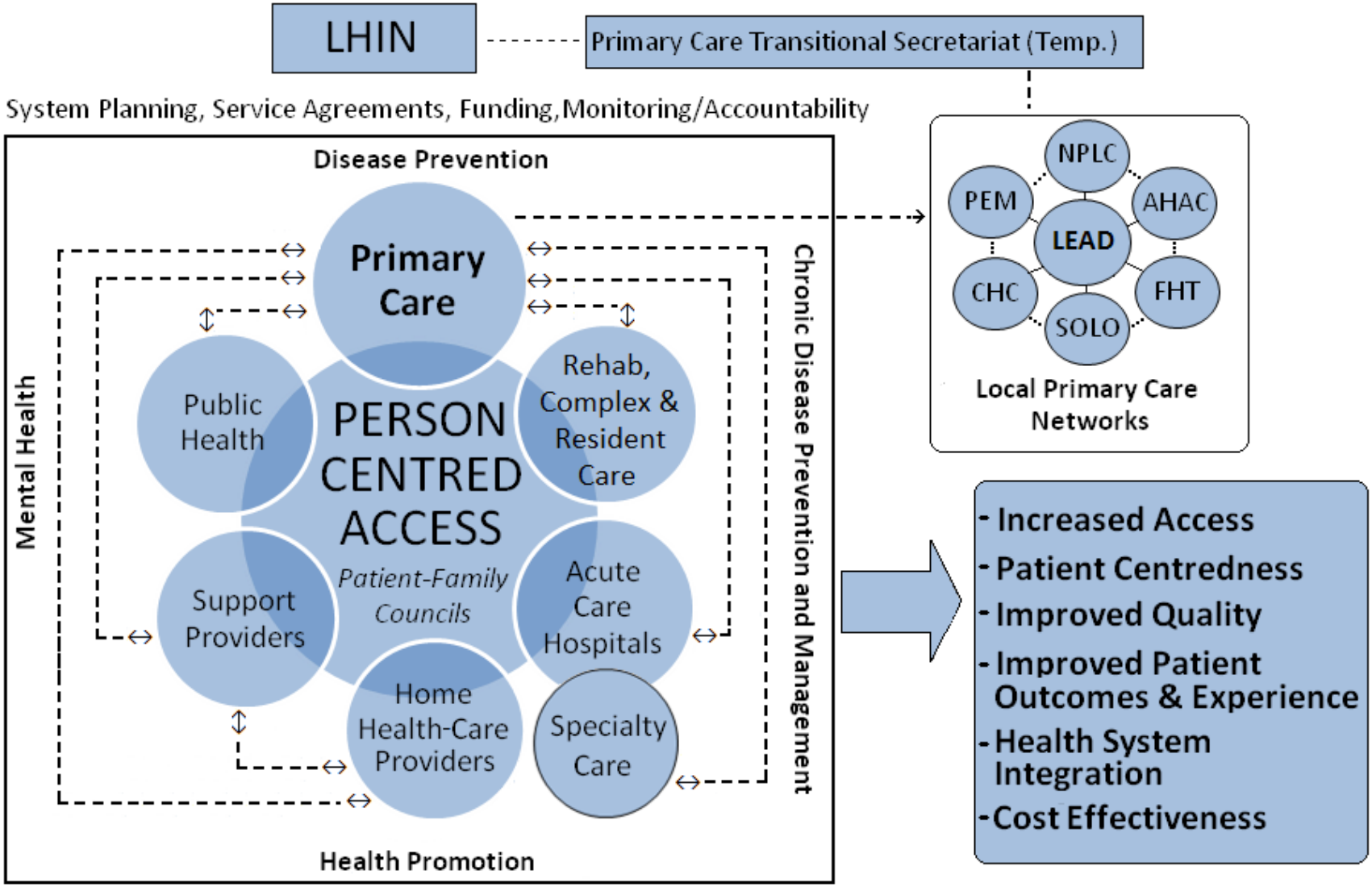


Table One – ECCO Model Transition Structure

RNAO provided government and stakeholders with a bold health system transformation plan -- ECCO - in October 2012. Given that RNAO believes time is of essence if we are serious about ensuring improved patients/clients/residents experiences and outcomes, as well as health system cost effectiveness -- we have not altered the timelines presented in ECCOs 2012 original version-- meaning Ontario is running out of time. Thus, ECCO 2.0 presents the pressing need for structural transition as follows:

Function	Leader	Transition Timeline
Creation of a Primary Care Secretariat (Transitional)	Local Health Integration Networks	December 31, 2012
Regional health system planning	Local Health Integration Networks	December 31, 2012
Establish geographic primary care networks	Local Health Integration Networks and Primary Care Organizations	December 31, 2012
No more new solo practice family physician models	Ministry of Health and Long-Term Care	December 31, 2012
Initiate labour management strategy as part of ECCO	Unions, Community Care Access Centres and Local Health Integration Networks	December 31, 2012
Contract management with providers	Local Health Integration Networks	December 31, 2013
Creation of Patient/Family Councils	Local Health Integration Networks	December 31, 2013
Rapid response nurses	Home Health-Care Providers	December 31, 2013
Nurse practitioner integrated palliative care program	Home Health-Care Providers	December 31, 2013
Health Care Connect	Primary Care Organizations	December 31, 2013
Mental health and addiction nurses in district school boards	Public Health Units (RNs) and Mental Health Programs (RPNs)	December 31, 2013
Expanded community laboratory services	Community Laboratories	December 31, 2013
Quality and performance management	Local Health Integration Networks	December 31, 2014
Completion of a Primary Care Secretariat (Transitional)	Local Health Integration Networks	December 31, 2015
IT infrastructure/Client Health and Related Information System (CHRIS)	Local Health Integration Networks and Primary Care Organizations	December 31, 2015
Long-term care home placement	Local Health Integration Networks and Primary Care Organizations	December 31, 2015
Care coordination	Primary Care Organizations	December 31, 2015
Discharge planning	Primary Care Organizations and Hospitals	December 31, 2015
Ordering home care services	Primary Care Organizations	December 31, 2015
System navigation	Primary Care Organizations	December 31, 2015
Completion of legislative/regulatory RN scope of practice enhancements	Primary Care Organizations	December 31, 2015
Complete labour management strategy	Unions and Local Health Integration Networks	December 31, 2015

Function	Leader	Transition Timeline
Transition all current solo family practice physicians to groups	Ministry of Health and Long-Term Care	December 31, 2015
Elimination of walk-in clinics	Ministry of Health and Long-Term Care	December 31, 2015
Public Health Units under LHIN mandate	Local Health Integration Networks and 36 Public Health Units	December 31, 2015
All Ontarians receiving care within a CHC, NPLC, AHAC or FHT	Primary Care Organizations	December 31, 2020
Delivering home-health care	Home Health-Care Providers	Ongoing
Providing support services	Support Service Providers	Ongoing

Table Two: Comparison of 'Health Links' and the ECCO Model.

It is helpful to consider the government's current health system transformation strategy in comparison with ECCO. While encouraging, there are areas where 'Health Links' can be strengthened in alignment with the vision expressed in ECCO.

	Health Links **December 2012**	**ECCO Model** **October 2012**	**Rationale for RNAO's Vision**
Purpose	To encourage local innovation to improve collaboration and co-ordination of care delivery.	To consistently adopt previously existing evidence and context to stimulate health system transformation, while adapting for local context based on population health needs.	While ECCO and Health Links share aims of collaboration and co-ordination, there is already significant evidence available to inform system transformation. Moreover, significant distinctions in approaches across the province may impede efforts for true co-ordination.
Target Population	Ontarians with the greatest health needs (i.e. the '5 per cent')	All Ontarians with specialized support for those with the greatest needs.	A balance must be struck in responding to those with existing complex needs and proactively preventing those 'on the edge' from becoming complex.
Role of Primary Care	Variable, however, many are enabling primary care to take a leading role.	Anchor of the health system.	Evidence demonstrates that the highest performing and most efficient health systems are anchored within primary care.

	Health Links December 2012	ECCO Model October 2012	Rationale for RNAO's Vision
Location of Care Co-ordination	Primary Care.	Primary Care.	The evidence supports that patient and system outcomes are maximized when care is co-ordinated within primary care.
Placement of Care Co-ordinators	Primary Care (as employees of CCAC).	Primary Care (as employees of primary care).	Transitioning CCAC Care Co-ordinators to primary care will support a vision for anchoring the health system in primary care, while eliminating duplication, inefficiency and maximizing current infrastructure, health-care expenditures, and roles.
Organization of Primary Care	LHIN-led voluntary process informed by the Institute for Clinical Evaluative Sciences (ICES) data and aligns with LHIN boundaries.	Initiate organization of primary care entities around people based upon naturally occurring referral patterns identified through ICES	The organization of primary care within ECCO's framework is supported by robust evidence generated through ICES.
Role of CCACs	CCACs are involved in most Health Links, serving as the lead agency in some instances.	CCACs are transitioned to existing structures within the health system, largely primary care and the LHINs.	Person-centred community care and overall health system care co-ordination cannot be achieved within the current CCAC model. Moreover, CCACs duplicate system processes at a significant cost to Ontarians.
Role of LHIN	Regional health system planner <u>for some</u> sectors.	Regional health system planner, funder and evaluator <u>for all</u> sectors.	The true potential of the LHIN as regional system integrator will not be achieved until the LHIN is fully enabled to achieve its full mandate.

Roles and Responsibilities within the ECCO Model

Local Health Integration Networks (LHIN)

The *Local Health System Integration Act* positions the role of LHINs as: system planners at the local level; integrators to produce co-ordinated care; community engagers; evaluators to assess local system performance and effectiveness; contributors to provincial health system plans; disseminators of best practices and knowledge; and funders of health services.[107] This legislation is framed directly within the context of: the *Canada Health Act* and the *Commitment to the Future of Medicare Act,* community-driven health outcomes, equity, diversity, integration and accountability.[108] Undoubtedly, LHINs are not presently performing to their full mandate and their role must now expand and strengthen to correspond with their legislative intent, placing greater emphasis on horizontal integration across all sectors according to population needs and community/geographical context. The potential also exists for LHINs to now fulfill their mandate of creating overall cross-sector system integration through local planning and community engagement. In early 2014, a review of the *Local Health Systems Integration Act* review is underway by the Legislature's Standing Committee on Social Policy. RNAO responded to this review calling for the inclusion of home health care organizations, primary care and public health units within the LHIN mandate.[109] This action will enable LHINs to effectively fulfill their true potential for whole system regional planning. Moreover, the timing of this review provides an excellent opportunity for policy makers to consider and adopt the ECCO model.

Within the ECCO model, the role of the LHIN leverages existing infrastructure, with minimal expansion, to accommodate the administrative functions of the CCAC. This role will involve contract management and ensuring accountability across sectors. It is important to note that the LHIN will serve an administrative/oversight role and will not possess structures that provide direct care, consistent with the *Local Health Systems Integration Act*. LHINs will also play a critical role in supporting the local organization of primary care, by establishing local primary care networks through a temporary 'Primary Care Transitional Secretariat'. This secretariat will focus on advancing the organization of primary care networks, development of common tools, and directing the transition of previous CCAC functions per the schedule outlined within the ECCO model. The secretariat is a temporary planning and monitoring structure and will not take on the previous roles of CCACs. Upon completion, the secretariat will dissolve and sustain progress of the primary care networks through the leadership of a primary care organization such as a CHC, NPLC, AHAC, or FHT with support from the LHIN.

LHINs will benefit from the creation of Patient/Family Councils that bring the patient perspective to health-care planning and decision making. While all health providers work diligently to improve client/patient health, their perspective comes from their professional backgrounds that are often not the same as that of clients/patients and families.[110] Establishing Patient/Family Councils will help the health system focus on person centred care planning and delivery of health services.

Inclusive of all sectors, LHINs will play a pivotal role in health systems planning using evidence and local population health needs. For example, the LHINs will develop a long-term care placement system that handles waitlists and oversees regional vacancies. These processes will be supported through the

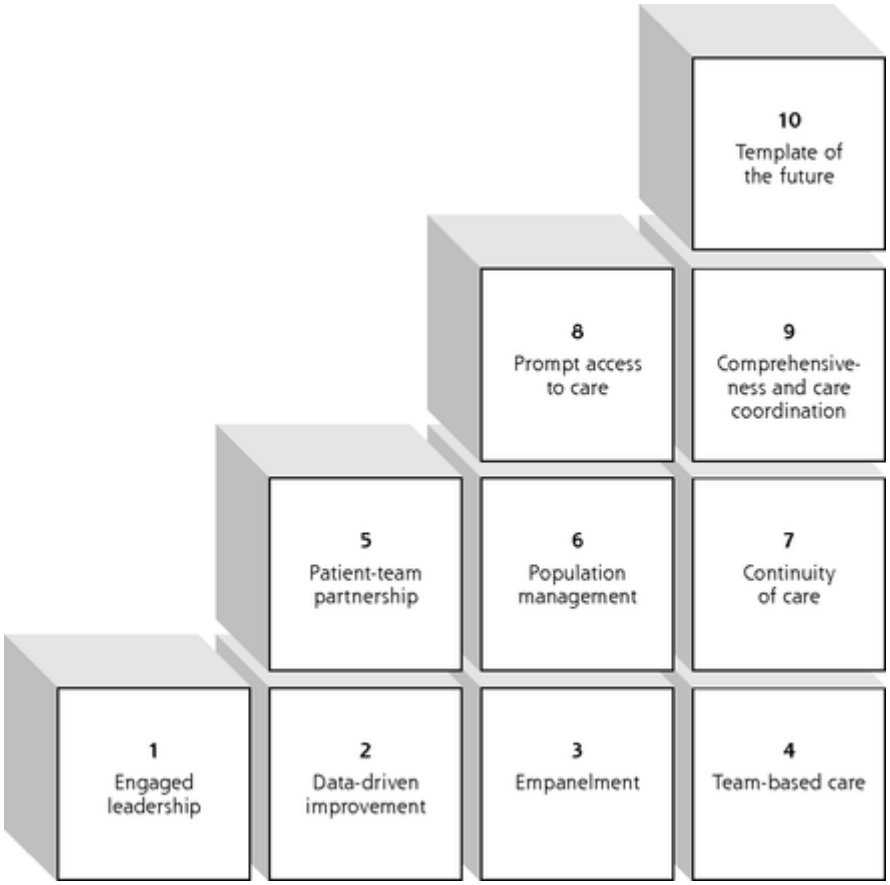
migration and adaption of current information technology infrastructure used by CCACs, to the LHINs to meet overall health system planning and accountability needs.

ECCO proposes that a system be developed involving LHINs, Health Quality Ontario, Accreditation Canada and the Canadian Centre for Accreditation (CCA) to assess and ensure quality care delivery is offered by service providers across the continuum. Metrics will include a combination of local and integrated care measures that will be identified upfront and applied consistently.

Primary Care Co-ordination

Bodenheimer et al. identify the 10 building blocks of a high-performing primary care setting as being[111]:

Figure Two: 10 Building Blocks of High Performing Primary Care



Bodenhemier et al. identify comprehensiveness and primary care-based care co-ordination as being key to a high-performing primary care setting, noting that "Improving care coordination requires teams … [and] high-performing practices often include a care coordinator … whose sole responsibility is care coordination."[112]

Primary care is the foundation of the ECCO model and represents a key service that must be heightened *to achieve primary health care for all. Primary care RNs must take a lead role in the care co-ordination* and system navigation process, in collaboration with other qualified professionals within the interprofessional team. The ECCO model proposes transitioning the approximately 3,500 care co-ordinators currently employed within CCACs into interprofessional primary care models with their salary and benefits intact. Primary-care based, RN-led care co-ordination for complex populations is well supported within the scientific literature.[113,114,115,116,117,118] Therefore, the 3,000 RN care co-ordinators will deliver expert care co-ordination and system navigation for the 10 per cent of Ontario's population that requires nearly 80 per cent of health-care resources. More specifically this role involves:

- Identifying the profile of this high-risk and complex population within the local area
- Attaching the population to the primary care organization(s)
- Developing a comprehensive and co-ordinated person-centred care management plan utilizing the strengths of the interprofessional team
- Managing primary care needs in collaboration with interprofessional team, including facilitating same-day access
- Reviewing social and environmental determinants of health and ensuring appropriate referrals or providing interventions directly
- Monitoring and evaluating health status and effectiveness of interventions regularly
- Collaborating with the hospital discharge planner
- Supporting safe and timely discharge from hospital to home or other location
- Making referrals for all home health-care and support services needed for their enrolled patients within the community
- Working with individuals and families to identify and secure optimal residential care placement, while co-ordinating with LHINs who lead the overall placement system (i.e. waitlists, vacancies, etc.)
- Serving as the vital link between the client and specialty care practices (i.e. diagnostic imaging, psychiatry, dermatology, orthopedics, etc)

The existing 4,000 RNs[119] currently practising in primary care, along with the remaining 500 CCAC care co-ordinators and other qualified primary care providers will provide the same services to the balance (90 per cent) of the population with varying levels of complexity across the lifespan. These individuals often experience minimal interaction with the health system and when care is required, it is typically for episodic illness. However, opportunities to focus on health promotion, disease prevention and the management of chronic disease should not be missed.

ECCO recommends educational and training programs, targeted towards primary care care co-ordinators to refine and /or enhance care co-ordination and system navigation competencies. This can

be accomplished by leveraging the extensive education capacity that currently exists within the health system. For example, RNAO's week-long Primary Care Nurse Institute utilized an expert faculty and a robust curriculum to support full scope of practice utilization of 87 primary care nurses to date. An entire component of the curriculum was devoted to enhancing care co-ordination and health system navigation competencies with excellent feedback received. Future offerings will occur in 2015 and beyond.

Currently within the health system there are specialized care co-ordinators outside of CCACs, who may or may not be RNs, that focus on providing dedicated support to clients concerning cancer, mental health, pediatrics and gerontological support. These providers work with the client for varying lengths of time, from weeks to years. The ECCO model retains and strengthens the effectiveness of this role through a close on-going connection with the primary care co-ordinator. Upon completion of the specialized relationship, the client transitions back to the primary care co-ordinator to enable care co-ordination and system navigation from 'womb to tomb'.

Primary Care Models

The ECCO model places a moratorium on the creation of new solo practice models in primary care as this impedes the progression towards interprofessional primary care teams. If government chooses to continue approving new solo primary care practices, horizontal and vertical integration of primary care, including the creation of primary care networks, planning processes, quality monitoring and improvement, service agreements, funding, quality monitoring and accountability will continue to be a substantive challenge. During this time, government will also need to transition the current 1,400 solo physicians (2010 data)[120] into group-based models of primary care delivery, as a step towards exclusive interprofessional primary care delivery. Many of these providers want to transition their practices into interprofessional teams, however, funding barriers prohibit them from doing so.

Government and LHINs urgently need to strengthen and expand interprofessional primary care delivery models. It is estimated that 25 per cent of Ontarians currently receive primary care in an organized interprofessional delivery model such as CHCs, NPLCs, AHACs and FHTs.[121] Over the next three years it will be critical for the government to expand established interprofessional care models where infrastructure capacity exists to increase patient enrollment and hours of care delivery. New CHCs, NPLCs, AHACs and FHTs should only be created where there is demonstrated need and no existing infrastructure capacity present. The goal of all of this work will be to have all Ontarians receiving care in a CHC, NPLC, AHAC or FHT, providing extended hours of care and full scope of practice utilization by December 31, 2020.

In the meantime, government can immediately begin to organize primary care delivery through horizontal integration. One way of doing this is through development of a temporary networked approach that aligns all different models of primary care to a network based on geographical health service grouping data, such as that currently being identified by the Institute for Clinical Evaluative Sciences (ICES). This type of model is being endorsed by Ontario's 14 LHINs[122] and closely complements the vertical integration proposed within the ECCO model. This transition will increase the capacity of current solo and group practitioners to access a primary care co-ordinator, as the role may be shared

across a network. In effect, the networks create a virtual team as an interim approach as the government continues to invest in the implementation of formal teams (CHCs, NPLCs, FHTs and AHACs). The networks can be anchored by a single primary care organization with opportunity to rotate this position. For example, an NPLC may choose to lead a network and provide connectivity with the local FHT and Family Health Organization within the area. The primary care co-ordinator can be located within the NPLC and provide outreach to these other organizations. Over time the network may shift the lead position and a transition in leadership occurs. This transition is meant to provide opportunities for leadership development and capacity building.

The relatively small proportion of Ontarians currently without access to primary care services will still be eligible to receive home care and support services. The ECCO model proposes a dramatic strengthening of Ontario's primary care system that will significantly increase the capacity and provide accessible primary care for all Ontarians who wish to receive it. For a significantly small portion of Ontarians not wishing to align themselves with a primary care model/provider, a special-access process will be developed whereby the patient can apply, through the LHIN, to be directly connected to a home health-care/support provider who will establish what the person's needs are and provide care accordingly. This is not unlike evolving developments in the province whereby certain clients can access publicly funded personal support service directly through support service providers. However, Ontarians will be actively encouraged to join primary care organizations to promote the continuity, comprehensiveness and improved health outcomes associated with a consistent primary care provider.

Primary Care Evidence-Based Practice

The use of evidence to guide quality outcomes in primary care is critically important. Evidence-based practice is necessary for advancing optimal patient outcomes and health system sustainability. This is why the Council of the Federation has placed an emphasis on implementing clinical practice guidelines, including national adoption of RNAO's best practice guideline *Assessment and Management of Foot Ulcers for People With Diabetes.*[123] Expansion of the *Excellent Care for All Act* occurring within primary care. Primary care organizations must take responsibility for creating an evidence-based practice culture. Leadership at the local level is critical to producing success. Significant local resources, supports and best practices are available to primary care organizations to make this happen. For example, the Best Practice Spotlight Organization initiative, led by RNAO, represents a partnership with 76 organizations across 320 cross-sectoral health-care sites around the world to implement and evaluate the impact of best practice guidelines on patient, organizational and system outcomes. [124] There are currently three primary care organizations (North Bay NPLC, Sandwich CHC and Two Rivers FHT) that are in varying stages of this initiative. Whether primary care organizations choose to pursue this designation or not, RNAO believes the time has come for a serious shift in primary care practice to align with the mandate of the MOHLTC, which is evidence-based care.

Primary Care Governance Models

The ECCO model identifies four levels of primary care governance: 1) Provincial governance offered by the MOHTLC in their role as broad system planners and stewards of Ontario's health system. The ECCO model proposes engaging the existing Ontario Primary Care Council, founded by key stakeholder

associations relevant to primary care, as the lead for this governance level. 2) Regional governance offered by the LHINs to plan and co-ordinate service and to focus on interactions/relationships between service providers within and across LHINs. This includes formally establishing and integrating Patient-Family Councils created in each LHIN. 3) Sub-regional 'governance' that will be developed amongst temporary primary care networks and built through the Primary Care Transitional Secretariat to organize primary care geographically within and across communities and stimulate a seamless patient experience across providers. 4) Local community governance offered within individual primary care models to oversee effective organizational operation.

Is Primary Care Ready?

RNAO believes that primary care is ready to deliver the role proposed by ECCO. In regions with established interprofessional primary care models (CHCs, NPLCs, FHTs and AHACs), RNAO asserts that the time is ripe to create primary care networks, where all sites, including solo providers, are connected. The networks will be organized in phases with support from the temporary Primary Care Transitional Secretariat within the LHIN. Moreover, these networks will accommodate the transition of care co-ordinators from CCACs into primary care, significantly increasing the capacity of the primary care sector. It is these networks that will stimulate the delivery of comprehensive primary care, including extended service delivery hours, complete care co-ordination and initiation of home health-care and support services. It is expected that these networks will provide after-hours service -- including overnight -- through rotating coverage by interprofessional primary care providers. In the few communities where it may be difficult to establish a primary care network, given the absence of an existing interprofessional primary care model, the ECCO model supports the creation of new CHCs, NPLCs, FHTs and/or AHACs in these regions.

Home Health Care

Home health-care providers will continue to lead front-line care delivery to Ontarians and the ECCO model enables this sector to focus on service priorities and full scope of practice utilization. The ECCO model envisions home health-care services becoming more robust and increasing, as savings from administrative and operating costs of CCACs (~191M) will be directly re-invested into hours of direct care delivery. Within the model, the primary care co-ordinator makes the initial referral for home care services and it is the home health-care organization that develops, monitors and refines a personalized care plan for the client while maintaining information sharing with primary care. Once home health care services are discontinued, a discharge summary will be sent to the primary care co-ordinator.

LHINs will serve as funders of home health-care organizations. The funding model will be reformed from a per-visit basis to funding baskets that follow evidence-based pathways that leverage provider knowledge and autonomy. In addition, the funding model will be stabilized, adjusting for seasonal variations to enable a greater proportion of full-time nursing employment within the sector. As a result of these changes, the role of the home health care nurse will evolve from a task-based care model to one that is more person-centred and encompasses a range of nursing interventions that include health promotion strategies. Provider assignment will be based upon client complexity, stability and

predictability of outcomes in alignment with RNAO's *Position Statement on Client Centred Care in Home Care* with an emphasis on continuity of care and continuity of care-provider.[125] The initial assessment of a new client must always be completed by an RN given any potential uncertainties that may exist.

Service contracts will be awarded by the LHIN through a non-competitive process that favours results-based quality. The ECCO model recommends that a moratorium is placed on the development of new for-profit service providers and that contract allocation amongst existing providers be prioritized based on quality outcomes and accountability. All home health-care providers will be required to undergo accreditation and a successful outcome will be a key factor for determining contract renewal. In order to ensure continuity in service provision, home health-care providers will be required to offer a range of accessible services that promote continuity and avoid fragmented care across different agencies. These services include nursing, personal support, and rehabilitation care.

There is great opportunity to introduce advanced practice nurses, such as clinical nurse specialists and nurse practitioners to the home health-care sector. Research exists validating the influence that clinical nurse specialists have on promoting positive client outcomes in the home.[126,127,128] Similar research validates the effectiveness of the nurse practitioner role in the home health-care setting.[129] Areas where advanced practice nurses can excel in the home environment include (but are not limited to): chronic disease prevention and management, pain management, wound care, palliation and care of older adults. Coupled with a steady supply of home health-care RNs and relationship with primary care, advanced practice nurses can minimize the need for physician house-calls, enabling physicians to focus their expertise elsewhere within the system.

Support Services

Exclusive emphasis cannot be placed on strengthening home health-care delivery as significant enhancement must be made to support service providers. Supporting Ontarians to lead healthy and productive lives within their homes and communities is absolutely dependent on the provision of robust support services, particularly those offered by not-for-profit providers. Support services include, but are not limited to: housekeeping, meal service, transportation, visiting/social support, day programs and so much more. It is critical that these providers be protected as distinct organizations to uphold the strong and reputable identities that have been established in communities across Ontario. Moreover, similar to the role being proposed for home health-care providers, support service providers must be provided with the leadership to autonomously identify and implement appropriate support plans with their clients, keeping in close contact with the primary care co-ordinator.

Mental Health and Addictions

A discussion on strengthening person-centred access to health care cannot occur without acknowledging the significance of mental health and addictions. It will be critical to not only protect the current resources and investments dedicated to mental health and addictions, but to strengthen them. Within the ECCO model, increasing efforts are dedicated to ensuring that mental health and addictions promotion and care is integrated within each area of the health system including (i.e. public health, primary care, hospital, home health-care, support services, long term care, etc.). For example, the capacity of the primary care setting must be enhanced to include assessments, brief intervention and

referral. This is in an attempt to: improve complete care co-ordination, access to mental health services - especially in rural areas - and reduce stigmatization. However, the need for specialized mental health and addictions services will continue and these services must be strengthened. Examples of these services include and are not limited to: assertive community treatment, intensive case management, home detoxification services and recovery homes. The relationship between mental health workers in the community and the primary care co-ordinator will also serve as an essential link to enhance the care pathways for persons struggling with mental health and addictions.

Public Health Units

Public health units in Ontario are mandated to provide programs and services through the *Health Protection and Promotion Act* and the Ontario Public Health Standards, issued by the MOHLTC. The Ontario Public Health Standards establish requirements for fundamental public health programs and services, which include assessment and surveillance, health promotion and policy development, disease and injury prevention, and health protection.[130]

Public health staff works to ensure safe food and water, and safe places to live and work, as well as to promote and support healthy options to keep Ontarians healthy. While public health has a role in monitoring and controlling disease, much of the programs, services and advocacy efforts focus on broader issues that affect health including the community context in which people live, and the social determinants of health. Public health recognizes that factors outside of the health care system have the most impact on the health of the overall population. A population-health approach to disease prevention, and health protection and promotion is utilized by health units to address these factors and create outcomes that impact the whole of the population. The strategies of the *Ottawa Charter for Health Promotion*[131] are widely used to carry out this work – building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting the health system to incorporate health promotion. The success of these strategies is dependent upon working in multi-sectorial partnerships with community members, community organizations, municipal governments, business and provincial government, in addition to organizations and care providers within the health care system. Public Health Units provide direct service to individuals to advance the health of communities (i.e. working with expectant mothers and families), while also focusing on providing broader community level interventions.

Structurally, there are 36 health units in the province, each with a board of health. The type of Board varies, with the current Board structures being[132]:

- 22 autonomous boards that operate separately from the administrative structure of their municipalities;
- 4 autonomous boards that are integrated into municipal structures;
- 4 boards that are councils of single tier municipalities; and
- 6 boards that are councils of regional municipalities.

Service delivery catchment areas of public health units are aligned with municipal boundaries; they may be within the geographical area of one, or several, LHINs.

Funding for most public health programs and services is cost- shared between the MOHLTC and the local municipality(ies). Other Ministries such as the Ministry of Children and Youth Services may contribute 100 per cent financially for specific programs (e.g. Healthy Babies, Healthy Children Program) while the MOHLTC provides 100 per cent funding for some, Dental and Oral Health programs (Healthy Smiles), and a portion of Tobacco Control programming (Smoke-free Ontario Act enforcement)).

Within the ECCO model, Public Health Units remain as intact entities with a goal of advancing primary health-care across the health system. The significant expertise of Public Health Units in the areas of addressing the social determinants of health and community engagement and consultation can serve as key enablers of health system transformation. To enable a greater degree of system co-ordination, Public Health Units will transition within the full potential of the LHIN mandate which extends beyond illness care. This change will allow LHINs to perform whole system planning at the regional level and will enable alignment of public health units and all sectors to focus on evidence-based population health planning priorities. To accommodate this evolution, the following factors must be adopted:

- Public health funding must be maintained and not lost to other areas of the system;
- Public health programming must be retained and enhanced;
- Public health local governance models must be retained (i.e. maintaining the municipal relationship and existing Boards of Health);
- The public health nursing role be protected and strengthened to fully recognize the contributions that public health nurses brings to the system;
- The identity of public health as contributing towards health and well-being must not be lost within a system that has been traditionally 'illness' focused;
- Performance measures be developed that are consistent with population health outcomes and the capacity/role of Public Health Units and
- Public health must be engaged as an active partner to facilitate health system transformation.

RNAO was honoured to engage the Community Health Nurses Initiatives Group (CHNIG) to conduct an analysis of the implications of transitioning Public Health Units within the LHIN mandate. This analysis forms key considerations that expand upon the points above to facilitate an effective implementation process (Appendix C).

The ECCO model transitions the mental health RNs practising in district school boards program to Ontario's Public Health Units. The focus of these nurses will continue to be on mental health, however, from a public health nursing perspective. Public health nurses have had a strong and established presence within Ontario's schools since the early 20th century.[133] Public health nurses will work closely

with primary care RN co-ordinators to support integration between primary care and public health. The expertise of public health units must be recognized by policy-makers and leveraged to support optimal health in the early stages of life, both within the school environment and broadly within the community. RPNs practising in district school boards do not meet the legislated requirements to become public health nurses and therefore, their expertise can be utilized in other mental health programs across the province (i.e. community treatment teams).

Public Health Units will continue to play a critical role in supporting health promotion, disease prevention and community mobilization/development. The work of public health programs as an integrated component of the health system will advance principles of primary health care and contribute to a long-term vision of primary health care for all.

Hospitals

The ECCO model will enable clients to leverage the full strength of the primary care and community care systems. Hospitals will become centers caring for persons with highly complex and acute illness and/or those requiring elective procedures, with all other care being provided in the community or in residential care facilities. To accommodate this service priority, it is imperative that hospitals retain a highly educated and skilled workforce to meet the increasing complexity of illness and changing demographics. This means that evidence-based staffing models must be implemented that uphold the competencies, knowledge and skill of professionals in alignment with patient needs to produce optimal outcomes. This does not mean substituting providers through 'down-skilling' or increasing reliance on unregulated care providers. The research clearly demonstrates the potential for sub-optimal outcomes in these circumstances.[134,135,136,137,138,139]

Current CCAC discharge co-ordinators within hospitals, possessing significant expertise of the community, will become permanent staff of the hospital to augment discharge planning capacity or may transition to another area of need. The role of the discharge co-ordinator will be to work with the hospital team to assess and prepare clients for discharge, from the moment they are admitted, in close collaboration with the primary care co-ordinator.

The Canadian Institute for Health Information identifies that in 2010/11 there were 996,884 hospitalizations in Ontario.[140] Assuming a 24 per cent reduction in hospitalizations that may be produced by the ECCO model, based on research findings from similar models, it can be estimated that once fully implemented the ECCO model could prevent up to 239,252 hospitalizations. The Ontario Hospital Association reports that in 2008/09 the average length of hospital stay in Ontario was 6.4 days.[141] Using conservative figures on hospitalization costs from the North East LHIN ($842.32/day[142]), effective implementation of the ECCO model could free up approximately $1.3B in resources to be invested according to evidence-based population health needs.

Rehabilitation, Complex and Residential Care*

Rehabilitative, complex and residential (long-term care, retirement homes and assisted living) care settings are central to achieving the vision set forth in ECCO. Each of these sectors must be optimized to meet the growing challenges that lay ahead.

Patient/client/resident complexity and acuity are rapidly increasing across all three of these areas requiring the full scope of practice utilization of the RN. The ECCO model proposes adequately funding these organizations to meet these rising demands and secure the RN presence and role as a leader in care delivery. This can be achieved by funding sufficient evidence-based and person-centred staffing models that establish a minimum RN service level requirement. RNs practising in these areas must be empowered to view themselves as experts and the system must acknowledge their tremendous role through ongoing measurement and articulation of the value provided. One way of achieving this is through the Nursing Quality Indicators for Reporting and Evaluation (NQuIRE®) database. NQuIRE collects, analyzes and reports comparative data on nursing-sensitive indicators reflecting the structure, process and outcomes of care arising from best practice guideline implementation in organizations participating in RNAO's Best Practice Spotlight Organization (BPSO®) designation.[143] With increasing emphasis being placed on quality improvement, RNs in these areas have a tremendous opportunity to assume leadership in not only collecting quality improvement data, but also in interpreting the data and addressing the outcomes.

There is a common need for ongoing capacity building of the RN that can facilitated through existing educational resources, self-assessment, evidence-based practice and promoting nursing certification, which may include (but not limited to): gerontology, rehabilitation, renal, neurological and palliative. Technology is a powerful tool that can be leveraged to enhance access to education while enabling collaborative learning environments. Within academia, the ECCO model proposes tremendous opportunity to integrate more content related to these areas within undergraduate curriculum, enabling greater opportunity for clinical placements and targeting adequate funding to address outstanding research gaps. Sector-specific opportunities include:

a) The ECCO model promotes the role of rehabilitative and complex continuing care as an important part of the health system that enables the transition from hospital to home. RNs and other professionals practising within these settings possess significant expertise to advance the aims of the ECCO model. The ECCO model focuses on discharge planning to maximize beds by transitioning patients to the most effective setting based on need, which involves securing adequate community support or residential care. Concurrently, discharge planning within the hospital setting can be optimized to avoid re-admission that occurs when transitioning care too early. The ECCO model transitions control of complex continuing care beds from CCACs to the care facilities directly to maximize capacity and outcomes. The flow and transition of people from hospital to rehabilitation/complex continuing care and eventually to community care will be co-ordinated through primary care RN co-ordinators.

b) Within residential care, the role of long-term care (LTC) homes will be to care for residents who, despite all efforts, are unable to receive care within the community. LTC home administrators will work closely with the primary care RN co-ordinator, the client, the family and the LHIN to ensure that an effective and timely placement system is implemented. The primary care RN co-ordinator will transition care to the LTC home and continue to see the resident to ensure a smooth transition and adjustment. To facilitate this process, amendments will need to be made

to the *Long-Term Care Homes Act,* which currently positions CCACs as co-ordinating LTC home admissions.[144] Furthermore, the ECCO model proposes a fundamental shift from a task-focus to a resident focus, while simultaneously shifting from a compliance focus to a culture of quality and evidence-based practice. This can be supported by assigning a LTC resident one RN or Registered Practical Nurse (RPN) per shift, with the most appropriate caregiver based on the resident's complexity and care needs and the degree to which outcomes are predictable. Evidence-based minimum service requirements should be adopted, including funding for no less than an average of 4.0 hours of nursing care per resident, per day and no less than .59 RN hours per resident, per day; with greater acuity requiring more hours of care. Resident clinical and social outcomes are maximized with a staff mix of: (1) one NP per LTC Home, with no less than one NP per 120 residents, (2) at least 20 per cent RNs, (3) 25 per cent RPNs and (4) 55 per cent personal support workers (PSWs), subject to increases that align with greater acuity. Two RNs working 24/7 per 100 beds are the recommended minimum to allow for surge capacity as it becomes necessary.

There is an ongoing need to increase subsidy of both long-term care and retirement homes with a general need to improve regulation within retirement homes. The ECCO model proposes that the system seek a greater understanding of the role potential of the RN in retirement homes and assisted living centres. Possible roles could include: palliation and comfort care, medication administration, delegation to unregulated providers, complex care, chronic disease prevention and management and addressing social needs. In retirement homes, RNAO has advocated for a minimum of 1.0 FTE RN per 100 residents and 1.0 FTE RPN per 50 residents, along with a daily minimum of 0.5 hours of activation and recreational therapy per resident. [145]

**Residential care includes Long-Term Care Homes, Retirement Homes and Assisted Living.*

Unions

Development of a comprehensive labour management strategy is critical to the success of the ECCO model. RNAO was pleased to engage the Ontario Nurses Association (ONA) in early consultations. However, ONA indicated that they were unable to partner in the development of a labour management strategy. Therefore, RNAO collaborated with experts in labour law (pro bono) to develop such a strategy (Appendix D) which identifies that the ECCO model can be implemented without disrupting the wages and benefits of current CCAC care co-ordinators when they transition to primary care. Labour leaders can play a vital leadership role implementing this strategy.

Professional Associations

ECCO positions professional and sectoral associations playing a central role in: developing and supporting the roll-out of the ECCO model, providing insight and expert advice, collaborating with government to promote action, advancing quality through evidence-based policy and practice, and monitoring progress and accountability. RNAO is committed to proactively participating in these efforts and will continue to play a leadership role.

Government

The government, through the MOHLTC should serve as the overall health steward with planning and funding functions for the system. The ECCO model is extremely cost effective for Ontario's health system. Given that the model leverages existing capacity and infrastructure, requiring only minimal expansion (i.e. Transitional Primary Care Secretariat within the LHIN) it can be estimated that the value of contract administration, monitoring and management of service levels within the LHIN will be between three to five per cent of the contract values. Therefore, a significant portion of the administrative savings generated by the ECCO model can create more hours of direct home health-care delivery (approximately $191.4M).

The ECCO model presents undeniable facts that demonstrate system challenges, opportunities and a clear path for action. It is up to government to make the final choices whether to anchor the system in primary care or hospital care; whether to emphasize illness care or prevention; whether to maintain structural duplication between CCACs, home health care, LHINs and others or advance integration; whether to fast track the move to interprofessional primary care teams and full scope of practice utilization or move slowly. ECCO offers a solid plan for serious person-centred system transformation and realignment. The MOHLTC can choose to adopt the ECCO Model as a provincial policy initiative and establish a clear implementation plan, milestones and targets. The public is ready.

Conclusion

In conclusion, a growing and aging population with complex needs and the increase in overall prevalence of chronic disease demands an upstream person-centred approach based on health promotion, disease prevention and early intervention to prevent costly complications. This demographic outlook requires a swift move to community care anchored in primary care and linked seamlessly with hospital care, home health care, support services and public health. Decisive action must be taken to improve outcomes for those with the greatest need for health services while strengthening Ontario's publicly-funded, not-for-profit health system. The ECCO model is a long overdue innovative solution to facilitating health system integration, improving client outcomes and health system effectiveness. Now is the time for ECCO, a model that provides a path to transform Ontario's health system.

Appendix A: Care Co-ordination Background and Evidence

Primary Care Communication

A survey of Ontario's community care providers identified serious gaps in information exchange and communication with the primary care setting.[146] Recent consultation across the province suggests "… that communication among primary care providers, hospitals and community care co-ordinators in particular, is not currently required. This often creates care gaps that everyone agrees should not exist."[147] A report released by the Change Foundation recommends that the linkage between community services and primary care in Ontario be strengthened to create an integrated pathway for clients. [148] The ECCO model creates the integrated pathway necessary for clients through effective care co-ordination and health system navigation.

Health System Navigation

Health system navigation is needed within Ontario and has proven to be an invaluable and beneficial service to clients in other jurisdictions.[149] It is recognized that health system navigators serve an important role in addressing client knowledge needs and removing barriers to care.[150] It is also well established that RNs thrive as health system navigators. The benefits of this area of nursing practice have been clearly demonstrated in the literature when RNs have assumed navigator functions to support clients across the highly complex cancer care continuum.[151,152,153,154] An evaluation of a national training client navigation program in the United States of America (USA) found that health professionals participating in the evaluation possessed a higher level of understanding of concepts provided in the course when compared to non health-professionals.[155] This literature clearly validates the ECCO model's view that RNs possess the broad system knowledge, expert clinical background and critical thinking skills required to derive the greatest benefit from health system navigation.

Value of Care Co-ordination

RN-led care co-ordination in hospitals has been identified as a cost-effective solution that has led to decreases in overall lengths of stay.[156] A review of 15 randomized trials looking at nurse-led care co-ordination programs suggest that programs with substantial in-person client contact can be cost-neutral and improve quality of care.[157] An extensive review of 43 systematic reviews on care co-ordination roles in a number of settings, addressing a number of conditions, found that overall positive outcomes were produced on the outcomes studied.[158] Examples of outcomes identified in the reviews include: improved continuity of care, reduced mortality and hospital admissions and improved adherence to treatment.[159,160] Clients without a care co-ordinator have been identified as more likely to experience communication issues between the primary care setting and other areas of the health system, such as the hospital.[161]

A survey of Ontario care co-ordinators in the community found that 72.7 per cent identify client-centredness as a feature of a well-integrated health system. Implementation of the ECCO model involves providing comprehensive, co-ordinated and dedicated person-centred support, through primary care, to the ten per cent of Ontarians that consume nearly 80 per cent of health resources, as identified within *Ontario's Action Plan for Health Care.*[162] In 2008, the Change Foundation held focus

groups with frequent users of Ontario's health system and acquaintances of people with multiple chronic conditions. The results of these discussions identify that this client population feels there is a lack of co-ordination and communication among providers, a lack of confidence regarding information sharing between providers and frustration when subjected to the same tests and assessments previously provided by other providers.[163] The ECCO model addresses these concerns by leveraging the strength and momentum that has been created in Ontario's primary care setting. Within the ECCO model, the primary care setting serves as the co-ordinating hub providing all Ontarians with the opportunity to experience improved co-ordination in their care, while providing dedicated support to clients with highly complex health and social needs. Moreover, the literature identifies that having a single point-of-contact within a health services organization can significantly ease health system integration.[164] Within the ECCO model, primary care RN co-ordinators are well positioned to serve as the point-of-contact for a client's interaction with the health system.

Primary Care-Based RN Care Co-ordination

The idea of providing dedicated and RN-led care co-ordination through primary care is not a new concept. In fact, a similar model called "Guided Care" was developed in the USA to improve the quality of care for co-morbid clients, particularly the elderly, while reducing caregiver burden and health-care costs.[165] Based out of primary care and leveraging the expertise of RNs, the principles of guided care include: assessment, planning, chronic disease self-management, monitoring, coaching, co-ordinating transitions between all sites and providers of care, educating and supporting caregivers and supporting clients in accessing community resources. [166] Within the guided care model, the primary care RN co-ordinates the provision of all health care including: specialist visits, hospital utilization, emergency department utilization, home care, hospice, rehab and social services.[167] The results of this model have been stunning. Seniors with multiple complex chronic conditions reported significant improvements in satisfaction with their care, improved care co-ordination and improved client activation.[168] Clients in the guided care model report improved access to care, improved wait-times and improved access to telephone consultation.[169] Research suggests that guided care clients experience 24 per cent fewer hospital days, 37 per cent fewer nursing home days, 15 per cent fewer emergency department visits, 29 per cent fewer home health-care visits and nine per cent more specialist visits.[170] Family caregivers report being impressed with the impact that guided care has on improving the overall quality of chronic disease care.[171] Nurses practising within the guided care model report high job satisfaction and physicians report satisfication with communications within the model and report having a better knowledge of the clinical characteristics of their clients with chronic illness.[172,173] The ECCO model boasts an evidence-based foundation as demonstrated through the growing body of research from similar applications of care co-ordination and health system navigation.

Overcoming Barriers to Care Co-ordination

Barriers to care co-ordination include a fragile primary care system, lack of interoperable electronic records, dysfunctional financing and a lack of an integrated system.[174] The ECCO model builds on the strengths currently existing within Ontario's health system. While continuing to grow, Ontario's primary care setting has developed considerably over the last ten years. Today there are 26 Nurse Practitioner-led Clinics, 73 Community Health Centres, 10 Aboriginal Health Access Centres and 200 Family Health

Teams in the province.[175,176,177] In 2009, 99.6 per cent of Ontarians living in communities greater than 30,000 people had access to a primary care provider within 30 minutes travel time.[178] While more work is needed in rural areas of the province, this is clearly a significant gain. While criticism has been made to suggest that primary care is 'over-burdened' to adopt the ECCO model, it is important to note that there is tremendous opportunity for growth within the sector through full scope of practice utilization and the realignment of resources.

Ontario is also well on its way to ensuring that all citizens have electronic health records. Today, more than eight million Ontarians have an electronic health record.[179] LHINs and the MOHLTC are working diligently to review funding systems and are making progress as demonstrated through the introduction of client-based funding models.[180] Lastly, the ECCO model will provide the integrated system that is required for effective care co-ordination. Bringing all of these factors together, this is an exciting time in the evolution of Ontario's health system and provides the foundation required for effective implementation of the ECCO model.

Appendix B: Organizations Consulted

The Registered Nurses' Association of Ontario (RNAO) would like to thank the many health system experts represented below who were consulted for their significant knowledge and expertise to develop the ECCO model. Please note that this list does not necessarily indicate endorsement of the model from the organizations or individuals included.

Association of Family Health Teams of Ontario (AFHTO)

Association of Ontario Health Centres (AOHC)

Canadian Association for People-Centred Care

CCAC Case Co-ordinators

Community Health Nurses Initiatives Group (CHNIG)

Fasken Martineau (Pro Bono)

George Smitherman - Chair. G & G Global Solutions/Former Minister of Health and Long-Term Care

Home Health-Care Nurses

Local Health Integration Networks (LHINs)

Minister of Health and Long-Term Care and Senior Ministry Officials

National Case Management Network of Canada (NCMN)

Ontario Family Practice Nurses (OFPN)

Ontario Nurses' Association (ONA)

Ontario Progressive Conservative Party

Ontario New Democratic Party

Ontario Community Support Association (OCSA)

Ontario Hospital Association (OHA)

Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP)

Patients Canada

Institute of Clinical Evaluative Sciences (ICES)

Nurse Practitioners' Association of Ontario (NPAO)

Quantum Transformation Technologies

Countless RNAO members, nurses, other health professionals and the public through webinars, teleconferences and meetings.

Appendix C: Public Health Analysis

The Community Health Nurses Initiatives Group, an Interest Group of RNAO, critically analyzed the ECCO model within the context of a proposed public health alignment within the LHIN mandate and have identified the following considerations to be addressed by policymakers to effectively facilitate the transition. It is important not to view these considerations as barriers; rather they can be seen as workable opportunities to be addressed as part of the implementation process.

Model Elements	Requirements	Considerations
Population health promotion and disease prevention	• Protect Core Public Health Programs • Dedicated and protected funding for core Public Health Programs consistent with the Ontario Public Health Standards as a minimum, with enhanced funding required to achieve the Ontario's Action Plan for Health Care. • Protection of funding for Public Health core programs from all sources including MOHLTC, local municipalities, other ministries, Health Canada funded projects, and special project grants from all sources • Continued focus on addressing the determinants of health • Maintenance of fundamental non-health partnerships with municipalities, social service agencies and other local and provincial groups and associations	The primary focus of public health is the health and well-being of the whole population by addressing the determinants of health and through the promotion and protection of health and the prevention of illness (Ontario Ministry of Health and Long Term Care, (2008) Ontario Public Health Standards). Recognition that Public Health is legislated under the *Health Protection and Promotion Act* and not the *Public Hospitals Act* which governs the majority of the system currently managed by the LHINs Over 40 pieces of legislation direct public health practice and activities, including the *Immunization of School Pupils Act*, *Clean Water Act*, and the *Smoke Free Ontario Act*. Boards of Health are responsible for the assessment, planning, delivery, management, and evaluation of a variety of public health programs and services that address multiple health needs, as well as the contexts in which these needs occur Inter-sectoral partnerships are critical to the success of the work of public health and would be strained if public health staff were diverted to focus on LHIN focused planning.

Model Elements	Requirements	Considerations
Municipal Cost Shared funding	• Protect the Municipal/ Provincial cost shared funding model for public health programming	Municipal Government has a vested interest in public health functions at a local level Guarantees local commitment to Public Health and to existing and emerging public health issues Supports development of locally relevant healthy public policy LHIN priorities consist of managing and developing an already over taxed illness based system. Integration of public health priorities must take precedent, which is currently achieved through our legislated municipal cost-share mode**l**
Autonomy of Decision–making in public health	• Maintain Board of Health and Medical Officer of Health Autonomy for decision making as legislated by the *HPPA*	Ontario Public Health governance models vary from autonomous or semi-autonomous to autonomous/integrated, single-tier and regional boards LHIN officials and administrators are appointed, and the creation of a structure in which the Board of Health would be reporting through the LHIN could potentially impact relationships with board members and local municipalities Ensures localized accountability and timely decision making for emergency response
Protection of Public Health Nursing Workforce	• Ensure public health nurses' roles are protected and that public health programming is not abandoned to address illness system priorities • Ensure preservation of the numbers of public health nursing	Public Health Nurses have strong ties with the community as a whole, within and externally from the healthcare system. This ensures strong partnerships, a focus on social programming, policy development, and a holistic focus on healthy communities to advance the public

Model Elements	Requirements	Considerations
	positions and increased positions in the future to achieve health promotion and disease prevention mandate	health agenda. Current LHIN structures, which focus on primary and acute care are not consistent with this fundamental Public Health practice Public Health Nurses are experts in the field of health promotion and primary prevention and use evidence-based strategies to address health at the population level. Any integration of these highly specialized practitioners into an illness-based system (including primary care) would weaken the population health focus that is vital to the health promotion and prevention mandate that leads to positive population health outcomes
Geographical Alignment of Public Health Units	• Maintain geographic service boundaries for public health units contiguous with municipal boundaries	Geographical boundaries for Public Health are currently established by municipal boundaries, which protects and facilitates legislated funding agreements and public health programming LHIN boundaries may not match well with public health's community partner boundaries, and resulting misalignment may strain relationships with partners and negatively impact the ability of public health to generate positive outcomes. Current municipal alignment supports and simplifies healthy public policy development Emergency response is coordinated at a municipal level and is based on municipal boundaries. Public health units are key partners in emergency response plans and a significant change in boundaries will have significant impact on emergency response capacity.

FASKEN MARTINEAU

PROPOSAL

The ECCO model proposes that interprofessional primary care organizations expand their reach and role so that by 2015, primary care organizations will provide complete care co-ordination and health system navigation for all Ontarians including referrals for home health-care and support services. The net effect of this will be that CCACs will no longer be needed and they would be eliminated.

Care coordinators working within CCACs would transition to the primary care setting.

The ECCO model proposes that the current salaries and benefits of CCAC care coordinators would be maintained when they become direct employees of the primary care organizations.

GOAL

How to ensure that if the ECCO model is adopted by the Government, the care coordinators maintain the existing wages and benefits they currently enjoy at the CCACs.

ANALYSIS

1. If the Government were to adopt this model and essentially transfer the work that is being performed by CCACs to the primary care organizations, it is likely that such action would constitute a "health services integration" under the *Public Sector Labour Relations Transition Act (PSLRTA)*. The term "health services integration" is defined as:

> an integration that affects the structure or existence of one or more employers or that affects the provision of programs, services or functions by the employers, including but not limited to an integration that involves a dissolution, amalgamation, division, rationalization, consolidation, transfer, merger, commencement or discontinuance, where every employer subject to the integration is either,
>
> a) a health service provider within the meaning of the Local Health System Integration Act, 2006, or
>
> b) an employer whose primary function is or, immediately following the integration, will be the provision of services within or to the health services sector

CCACs are designated health service providers under the *Local Health Systems Integration Act* and so are not for profit corporations without share capital incorporated under Part III of the *Corporations Act* that operate community health centres. Another designated health service provider is " a person or entity approved under the *Home Care and Community Service Act* to provide services. Government should make it clear in the legislation it passes to give effect to the ECCO model that the transfer of functions from the CCACs to the primary care organizations will, in fact, constitute a "health services integration" within the meaning of *PSLRTA*.

2. If *PSLRTA* does apply what will happen is this: when the work (and care co-ordinators) are transferred from a unionized CCAC to a primary care organization, the union that represented theses employees at the CCAC will, initially continue to represent them and their current collective agreement will continue to apply. The new employer and the union which represented the former CCAC employees might be content to maintain that bargaining unit with the result that it would only cover the former CCAC employees and not the new employer's existing employees. If that was the case the collective agreement will continue until its expiry date and then a new agreement will have to be negotiated. To the extent the Government provides sufficient funding to the primary care organization (the new employer) it would likely maintain the wages and benefits the employees received while they were CCAC employees.

Instead of simply maintaining the old bargaining unit of former CCAC employees the new employer may wish to have a new bargaining unit which would consist of not only the former CCAC employees who transferred over but also that employer's existing employees. The parties can either agree to this or if there is no agreement and one of the parties is insistent on a new bigger bargaining unit, the Labour Board would have to decide whether the proposed new bargaining unit would be appropriate. If it decides that it is appropriate, the next question would be which union should represent the new bargaining unit. Usually this is determined through a vote. If a union represented any of the former employees of the CCAC who transferred over that union would be on the ballot. If a union represented any of the employees of the new employer (the primary care organization) before the transfer took place that union would also be on the ballot. There could also be a no union choice on the ballot but this would only happen if at least 40% of the total employees of the new employer were non union prior to the transfer. Depending on what happens in the vote the winning union's existing collective agreement will continue until its expiry and then a new agreement will have to be negotiated. The situation will essentially be the same as that described in the previous paragraph. If the Government provides sufficient funding it is likely that the new employer will maintain or even increase the wages and benefits the employees had while they were employed at the CCAC.

3. For *PSLRTA* to be applicable, either the predecessor employer's (the CCAC) employees have to be unionized or the new employer's (the primary care organization) employees have to be unionized. If both are non-union then *PSLRTA* would have no application. We know that 10 of the 14 CCACs are represented by the Ontario Nurses Association (ONA). Hence any transfer of employees from those CCACs to a primary care organization will likely result in *PSLRTA* being applicable in which case what we have described above ill apply. If the other CCACs are non-union (which is unlikely) and the employees of those CCACs are transferred to primary care organizations whose employees are not represented by a union, then the new employer will be free to determine, all by itself, what wages and benefits it pays its employees. If it receives sufficient funding from the Government it may choose to maintain the wages and benefits that the former CCAC employees enjoyed while they were employed by a CCAC.

4. There is an increased likelihood of maintaining the wages and benefits enjoyed at CCAC if the parties were forced to go to interest arbitration to resolve outstanding issues when they reached an impasse at bargaining. Interest arbitration is what applies to the public hospital sector, the long term

care sector, firefighters and a few other groups. Interest arbitrators, in general, tend to be more generous in their awards than what is obtained through free collective bargaining.

CONCLUSION

Ultimately, whether the wages and benefits received by care coordinators at the CCACs can be maintained when these individuals transfer to the primary care organizations will depend on whether the Government sufficiently funds these organizations. It is our understanding that RNAO's ECCO model proposes that the government re-allocate existing salary/benefit funding currently held by CCACs to the primary care organizations, thus increasing the ability to maintain current wages and benefits.

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