



RNAO

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

ECCO
T H R E E Y E A R P L A N

**ENHANCING
COMMUNITY
CARE FOR
ONTARIANS**

ECCO 1.0

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

White Paper

Executive Summary

Ontario's nurses 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 and more efficient and cost-effective. To make this happen, focus must be placed on 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.¹ 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, Ontario's home health-care and support services are organized by 14 Community Care Access Centres (CCAC) that utilize nearly \$2 billion of public resources each year. In 2008/09, \$163M in operational and administrative costs was expensed by CCACs,² demonstrating significant growth in administrative budgets that outpace growth in direct care dollars. At the same time, duplication and role conflict exists between CCACs, primary care, acute 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 transitioning the functions of CCACs into existing structures within the health system over the next three years – a proposal outlined in *Enhancing Community Care for Ontarians (ECCO)* model. Using the analogy of an eco-system, RNAO has 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.

The ECCO model 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 three years, with the support of a temporary LHIN-led Primary Care Transitional Secretariat to organize local geographic primary care networks. The ECCO model proposes that by 2015 primary care organizations will provide complete care co-ordination and health system navigation for all Ontarians, including the referral for home health care and support services, thus eliminating the need for CCACs. Current Registered Nurse (RN) case managers and care co-ordinators working within CCACs, would transition to the primary care setting and

contribute their high level of expertise and system knowledge to provide dedicated care co-ordination and health system navigation to Ontarians with the most complex care needs. The remaining population will receive care co-ordination from a combination of existing primary care RNs, non-RN case managers/care co-ordinators and other qualified primary care providers.

The ECCO model maintains the current salary and benefits of CCAC case managers and care co-ordinators, using the current funding envelope available, as direct employees of primary care organizations. The model will strengthen 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 mode 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 community care and improves integration between all health sectors through a single health system planner and funder – the LHINs as maturing system structure. Specifically, the paper provides an overview of the ECCO model to inform and evolve strategies to ensure timely access to Ontario’s health system, improve client experience and outcomes, and deliver comprehensive services in a cost-effective and seamless manner.

Introduction

A lingering recession, compounded by Prime Minister Stephen Harper's decision to both distance his government from renewing a Health Accord that expires in 2014, and reduce health transfer payments by 2018, forces jurisdictional leaders to critically examine policy and funding imperatives and make important choices.

Some jurisdictional 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 and other forms of privatization. This approach will prove to be a political nightmare because it delivers less quality at higher costs.^{3,4,5} The second approach, and the one supported by nurses, is to strengthen our publicly-funded, not-for-profit health system, advance primary health care for all and make 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.

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."⁶ 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.⁷ 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.^{8,9,10,11,12} Studies also show that receiving care at home is considerably less expensive for the health system.^{13,14} 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.¹⁵ 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.¹⁶

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.¹⁷ 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).¹⁸ 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 are introduced in the *Enhancing Community Care for Ontarians (ECCO)* model. Using the analogy of an eco-system, RNAO has 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 in which it is applied. Moreover, a key goal of this work is to stimulate a ripple or 'echo' effect across each sectors of the health system to improve client care and system effectiveness.

As the professional association representing registered nurses (RNs) working in all roles and sectors in Ontario, RNAO believes it has both a duty and a responsibility 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 three year transition where the functions of the Community Care Access Centres (CCACs) are transferred to strengthened areas of the health system, leaving behind heavy layers of administration and bureaucracy. 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. 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.¹⁹ RNAO has long been on record in proposing that aging in place is imperative, both for older persons and for creating vibrant communities.^{20,21,22} 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.

As a result, a key challenge facing Ontario's health resources is that 10 per cent of the population accounts for approximately 80 per cent of health spending.²³ While consensus has not been reached on the composition of this population-segment, it likely includes a portion of seniors living with multiple co-morbidities, persons with complex mental health challenges, and other vulnerable populations. However, it is important to flag that not every senior 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.²⁴ However, at the same time 77 per cent of Canada's seniors also reported their health status as being excellent, very good or good.²⁵ Moreover, one in four Canadian seniors do not report having any chronic conditions at all.²⁶ Similarly, one in five Canadians, from all backgrounds and walks of life, will have a mental illness in their lifetime²⁷ and the degree of morbidity experienced will highly vary across this group. 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 community care services to achieve primary health care for all. Ontario's nurses are determined and ready to make this happen. Nurses also understand that action must be taken to contain increases in 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)

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 care²⁸
- Develop and deliver a competitive bidding process for service procurement

Today, Ontario has 14 CCACs employing approximately 5,600 people and providing services to about 604,000 Ontarians.²⁹ The annual budget for CCACs is around \$2 billion.³⁰ 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 providers to offer: nursing, personal support, homemaking, home support, occupational therapy, speech language pathology, physiotherapy, dietetics and social work services.³¹ Until 2008, a competitive bidding process was used to procure service contracts that saw providers bidding against one another.³² 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.^{33,34} 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.^{35,36}

CCAC Structure

The largest component of CCAC staff are case managers and care co-ordinators 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.”³⁷ There are approximately 3,500 case managers

and care co-ordinators employed in CCACs across Ontario, many of whom are nurses, physiotherapists, occupational therapists, speech language pathologists and social workers.³⁸ The great majority of CCAC case managers and care co-ordinators are RNs – about 3,000 – a role well suited for their comprehensive competencies and education in health and social sciences. Other functions served by CCACs include discharge planning, long-term care home placement and administering programs such as Health Care Connect.^{39,40} 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.⁴¹ The latter programs suggest that the CCACs are taking on a more direct care role, which was not their intended purpose. The CCAC system does not possess the structure, mandate or capacity to deliver direct care to Ontarians. Moreover, this inappropriate function of the CCAC is destabilizing the community care workforce.

It is critical to flag that the shortcomings of the CCAC system are **not** the fault of the dedicated case managers and care co-ordinators who find they are working within a broken system. 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 for their clients.

CCAC Performance

Use of Funding

CCACs are neither adequately nor efficiently fulfilling their prescribed 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.⁴² 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.⁴³ 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.⁴⁴

In 2008/09, \$163M, representing 9.3 per cent of the total provincial CCAC budget, was spent on CCAC administration.⁴⁵ 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.⁴⁶ An analysis conducted by the Hamilton Spectator identified that in 2010, the total administrative expenditures for the operation of 14 LHINs was \$68M.⁴⁷ 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 salary disclosure data that is publicly reported each year, 228 senior CCAC staff reported incomes over \$100K totaling approximately \$29M in salary costs in just one year.⁴⁸ Assuming a 20 per cent benefit rate, this brings the total cost to approximately \$34.8M. Of these 228 staff, only four are case managers and six are Nurse Practitioners.⁴⁹ The remaining 218 employees are senior managers. The

CCACs also 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.⁵⁰ 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.⁵¹ Over a three year period, the number of CCAC staff has increased by over 10 per cent.⁵² These numbers raise serious doubts as to whether the CCAC model is the most cost efficient way to oversee community care in the province.

Performance and Impact for Ontarians

There are also concerns over whether CCACs are structured to handle increased shifts of care to the community given that they are struggling to handle 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.⁵³ 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.⁵⁴ In fact, these delays accounted for 16 per cent of total hospitalized days in Ontario's health system.⁵⁵ CCACs are also struggling to provide the co-ordinated, quality care that Ontarians deserve. For example, a study on wounds in two CCACs found significant gaps between care of foot/leg ulcers and best practices.⁵⁶ CCACs are limited in their 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.⁵⁷ 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 LHIN⁵⁸, 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.⁵⁹ It is unclear what proactive action CCACs are taking to prevent costly hospitalization. It is also unclear what action is being taken to manage the complex care requirements of vulnerable segments of the population. The end result is a patchwork system that is not co-ordinated or continuous. As the Ontario Association of 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."⁶⁰ It is neither in the public's interest nor the Ontario government's interest to pump resources 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.

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."⁶¹ This appointment was based on a recommendation from the Waterloo Wellington LHIN following an organizational review.⁶² This review raised significant concerns over leadership and ongoing service restrictions resulting in "on-again/off-again" client care.⁶³ 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."⁶⁴ In reality, the OACCAC operates as a taxpayer funded advocacy group, lobbying the government to advance the needs of CCACs. The operating budget of the OACCAC is not publicly reported, however, an analysis of 2011 salary disclosure data identified that approximately \$4.7M (\$5.6M assuming 20 per cent benefits) is expended annually just for the human resource costs of 35 senior staff.⁶⁵ A job description for a Senior Director of Information Technology (IT) at the OACCAC identifies an IT budget of approximately \$13.5M that largely is expended to external vendors.⁶⁶ 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.

The Need to Evolve CCACs

The report of the Commission on the Reform of Ontario's Public Services questioned the future existence of CCACs and specifically recommended integrating them within the LHINs. 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.⁶⁷ 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 task force that care co-ordination and system navigation must operate out of primary care. A working definition of care co-ordination has been 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."⁶⁸ An important facet of care co-ordination is health system navigation which can be defined as: "[offering assistance] to clients in "navigating" through the complex health system to overcome barriers in accessing quality care and treatment."⁶⁹ *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.⁷⁰

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. Primary care RNs are well situated with the educational preparation, clinical knowledge/experience, public trust, complete health system knowledge 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 4,285 primary care nurses in Ontario, of which 2,873 are RNs.⁷¹

It is clear that a person-centred model must be implemented that enables primary care RNs and other qualified 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:

- Strengthening Ontario's publicly-funded, not-for-profit health system by achieving timely access and system cost-effectiveness
- Person centredness, including clients, families, and caregivers
- 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
- Leveraging the expertise of public health to inspire community engagement and population health planning
- Developing robust home health-care and community support services
- Eliminating structural duplication, and facilitating health services integration
- Improving continuity of care through consistent interactions with providers and the elimination of walk-in clinics/unnecessary emergency department utilization
- Maximizing and expanding the scope of practice utilization of all regulated health professionals

- Focusing expert attention on Ontarians with complex needs that require the greatest proportion of health-care resources
- 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

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

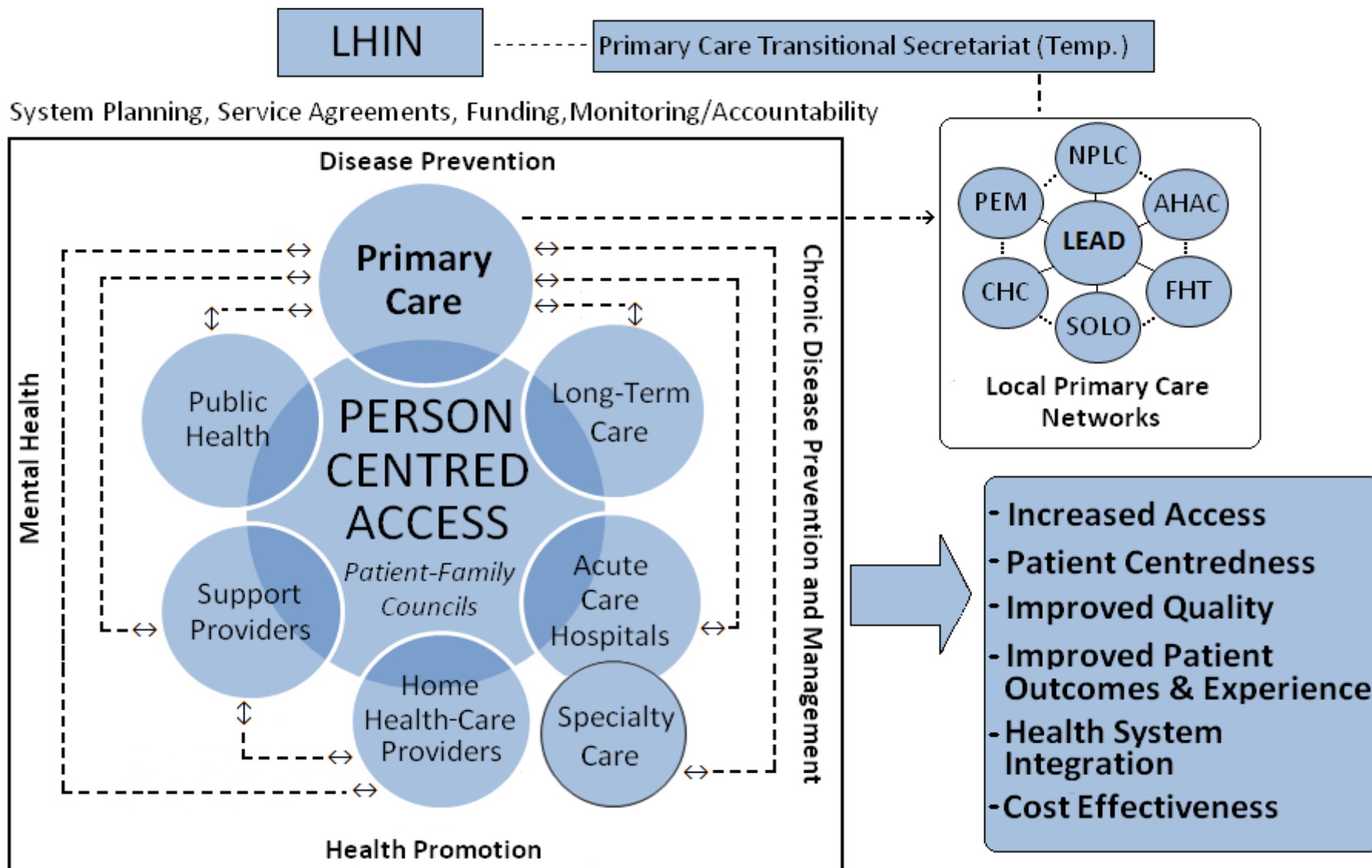


Table One – ECCO Model Transition Structure

The proposed transition structure to fully implement the ECCO model is as follows:

Function	Leader	Transition Timeline
Creation of a Primary Care Secretariat (Transitional)	Local Health Integration Networks	December 31, 2012
Integrated client care project	Local Health Integration Networks	December 31, 2012
Local planning	Local Health Integration Networks	December 31, 2012
Contract management	Local Health Integration Networks	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
Creation of Patient/Family Councils	Local Health Integration Networks	December 31, 2015
Establish geographic primary care networks	Local Health Integration Networks and Primary Care Organizations	December 31, 2012
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
Health care connect	Primary Care Organizations	December 31, 2013
Care coordination	Primary Care Organizations	December 31, 2015
Discharge planning	Primary Care Organizations and Acute Care Hospitals	December 31, 2015
Ordering home care services	Primary Care Organizations	December 31, 2015
System navigation	Primary Care Organizations	December 31, 2015
All Ontarians receiving care within a CHC, NPLC, AHAC or FHT	Primary Care Organizations	December 31, 2020
Completion of legislative/regulatory RN scope of practice enhancements	Primary Care Organizations	December 31, 2015
Delivering home-health care	Home Health-Care Providers	Ongoing
Rapid response nurses	Home Health-Care Providers	December 31, 2013
Nurse practitioner integrated palliative care program	Home Health-Care Providers	December 31, 2013
Providing support services	Support Service Providers	Ongoing
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
No more <u>new</u> solo practice family physician models	Ministry of Health and Long-Term Care	December 31, 2012
Transition all current solo family practice physicians to groups (i.e.FHO)	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

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; robust 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.⁷² 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.⁷³ Undoubtedly, LHINs are not presently performing to their full mandate and their role must now expand and strengthen to correspond with the 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.

Within the ECCO model, the role of the LHIN leverages existing infrastructure, with minimal necessary expansion, to accommodate the administrative functions of the CCAC. This role will involve contract management and ensuring accountability within home health-care and support services. 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. After three years, the secretariat will dissolve and sustain progress of the primary care networks through the leadership of a primary care organization such as a CHCs, NPLCs, AHACs, or FHTs 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 which are often not the same as that of clients/patients and families.⁷⁴ 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. The LHINs will also assume the leadership required to evaluate the Integrated Client Care Project and determine appropriate application within the delivery of home health-care services.

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

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 primary care providers within the interprofessional team. The ECCO model proposes transitioning the approximately 3,500 case managers/care co-ordinators currently employed within CCACs into interprofessional primary care models. Primary-care based, RN-led care co-ordination for complex populations is well supported within the scientific literature.^{75,76,77,78,79,80} Therefore, the 3,000 RN case managers/care-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 care management plan utilizing the strengths of the interprofessional team
- 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 long-term care home placement, while co-ordinating with LHINs who lead the overall placement system (i.e. waitlists, vacancies, etc.)
- Managing primary care needs in collaboration with interprofessional team, including facilitating same-day access

The existing 2,873 RNs⁸¹ currently practising in primary care, along with the remaining 500 CCAC case managers/care co-ordinators and other qualified primary care providers will provide the same services to the balance (90 per cent) of the population with less complex health and social needs. 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. While the ECCO model fully acknowledges that there is opportunity for other (non-RN) qualified primary care providers to deliver care co-ordination services, the remainder of this paper will focus on primary care-based RN co-ordination, given the evidence referenced.

ECCO recommends educational and training programs, targeted towards primary care RN 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 planned for 2013 that utilizes expert faculty and a robust curriculum to support full scope of practice utilization of primary care nurses.

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 illness 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 RN co-ordinator. Upon completion of the specialized relationship, the client transitions back to the primary care RN co-ordinator to enable care co-ordination and system navigation from 'womb to tomb'. Moreover, the primary care RN co-ordinator will serve as the vital link between the client, primary care and specialty care practices (i.e. diagnostic imaging, psychiatry, dermatology, orthopedics, etc). Currently, this connection is often a source of significant frustration for clients and providers, resulting in communications gaps, service delays, duplication, and avoidable health system expenditures.

Primary Care Models

The ECCO model places a moratorium on the creation of new solo practice models in primary care. 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, 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)⁸² into group-based models of primary care delivery, as a step towards exclusive interprofessional primary care delivery. This transition will increase the capacity of current solo practitioners to access a primary care RN co-ordinator, as the role may be shared within a group.

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.⁸³ 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 (i.e. RN prescribing, suturing, etc), by December 31, 2020.

In the meantime, government must immediately begin to organize primary care delivery through horizontal integration. One way of doing this would be through development of a 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 LHINs⁸⁴ and closely complements the vertical integration proposed within the ECCO model.

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 LHIN will directly connect the person to a home health-care/support provider who will establish what the person's needs are and provide care accordingly. 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 COF 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*.⁸⁵ Expansion of the *Excellent Care for All Act* is needed and likely to occur 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 almost 300 cross-sectoral health-care sites around the world to implement and evaluate the impact of best practice guidelines on patient, organizational and system outcomes.⁸⁶ 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. 3) Sub-regional ‘governance’ that will be developed amongst 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.

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 sees home health-care and community support services becoming more robust and increasing, as savings from administrative and operating costs of CCACs will be directly re-invested into hours of direct care delivery. Within the model, the primary care RN co-ordinator makes the initial referral for home care services and the home health-care organization develops, monitors and refines a personalized care plan for the client. Once home health care services are discontinued, a discharge summary will be sent to the primary care RN co-ordinator.

Service contracts will be awarded through a non-competitive process that favours results-based quality. The ECCO model recommends that a moratorium be placed on the development of new for-profit service providers and direction that current not-for-profit providers receive priority contracts. 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. Outcome-based funding will flow in baskets, based on best practices, directly from the LHIN to the home health-care organization.

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 RN co-ordinator and team.

Mental Health Care

A discussion on strengthening person-centred access to health care cannot occur without acknowledging the significance of mental health. It will be critical to not only protect the current resources and investments dedicated to mental health, but to strengthen them. Within the ECCO model, mental health 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.), rather than existing as separate structure. 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 addiction 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.

Public Health Units

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.⁸⁷ Public health nurses will work closely with primary care RN co-ordinators to support integration between primary care and public health. Public Health Unit funding will remain intact through the ECCO model and these organizations 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

Current CCAC discharge co-ordinators within hospitals may become 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 assess and prepare clients for discharge, from the moment they are admitted, in close collaboration with the primary care RN co-ordinator. The ECCO model will enable clients to leverage the full strength of the primary care and community care systems, allowing hospitals to focus resources on caring for clients with high acuity that demands intense nursing and medical care requirements that cannot be managed at home.

The Canadian Institute for Health Information identifies that in 2010/11 there were 996,884 hospitalizations in Ontario.⁸⁸ 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.⁸⁹ Using conservative figures on hospitalization costs from the North East LHIN (\$842.32/day⁹⁰), effective implementation of the ECCO model could save the health system \$1.3B in hospitalization costs when fully implemented. All of these savings would be re-invested into front-line care delivery within the home and community, beginning with the immediate reinvestment of administrative and infrastructure savings generated by the ECCO model.

Long-Term Care Homes

Within the ECCO model, the role of long-term care (LTC) homes is 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.⁹¹

Unions

Development of a comprehensive labour management strategy will be key to the success of the ECCO model. The Ontario Nurses' Association (ONA) in close collaboration with other labour leaders, such as the Ontario Public Service Employees Union (OPSEU) and the Canadian Office & Professional Employees Union can play a vital leadership role developing this strategy. RNAO believes it is critical to reinforce that within the ECCO Model the income and benefit security of case managers and care co-ordinators, currently employed in the CCAC, must be retained within primary care.

Professional Associations

RNAO sees 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

Government, through the MOHLTC, serves as the overall system planner and funder. 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 will be between three to five per cent of the contract values. Using conservative figures from the 2010 Auditor General's report, up to \$163M in administrative funding from CCACs⁹² can be reinvested into the direct delivery of home health-care and support services. This translates into the government funding the delivery of up to an additional 4,075,000 hours of direct home health-care for Ontarians. It is important to note that this figure is based on 2008/09 data and the administrative budgets of CCACs have increased since that time.

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 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 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 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 and community support services. 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.⁹³ 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.⁹⁴ 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.⁹⁵ It is recognized that health system navigators serve an important role in addressing client knowledge needs and removing barriers to care.⁹⁶ 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.^{97,98,99,100} An evaluation of a national training client navigation program in the United States of America (USA) found that while there was a need to develop an education program and provide ongoing education to support health system navigation, health professionals participating in the evaluation possessed a higher level of understanding of concepts provided in the course when compared to non health-professionals.¹⁰¹ 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.¹⁰² 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.¹⁰³ An extensive review of 43 systematic reviews on care co-ordination in a number of settings, addressing a number of conditions, found that overall positive outcomes were produced on the outcomes studied.¹⁰⁴ Examples of outcomes identified in the reviews include: improved continuity of care, reduced mortality and hospital admissions and improved adherence to treatment.^{105,106} 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.¹⁰⁷

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*.¹⁰⁸ 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.¹⁰⁹ 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.¹¹⁰ 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.¹¹¹ 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.¹¹² 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.¹¹³ 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.¹¹⁴ Clients in the guided care model report improved access to care, improved wait-times and improved access to telephone consultation.¹¹⁵ 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.¹¹⁶ Family caregivers report being impressed with the impact that guided care has on improving the overall quality of chronic disease care.¹¹⁷ Nurses practising within the guided care model report high job satisfaction and physicians report satisfaction with communications within the model and report having a better knowledge of the clinical characteristics of their clients with chronic illness.^{118,119} 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.¹²⁰ 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.^{121,122,123} 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.¹²⁴ While more work is needed in rural areas of the province, this is clearly a significant gain. 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.¹²⁵ 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.¹²⁶ 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)
CCAC Case Managers
Community Health Nurses Initiatives Group (CHNIG)
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 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)
Institute of Clinical Evaluative Sciences (ICES)
Patients' Association of Canada (PAC)
Nurse Practitioners' Association of Ontario (NPAO)
Ontario Family Practice Nurses (OFPN)

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