CCACs Under Attack? ONA is Fighting for You!

A report issued in October 2012 by the Registered Nurses’ Association of Ontario (RNAO) contained the recommendation to eliminate Ontario’s 14 Community Care Access Centres (CCACs), calling them a “duplication of existing services and bureaucracy.” We do not agree!

ONA has been speaking to the Ministry of Health and Long-Term Care (MOHLTC) to ensure that government policy-makers understand the important role and responsibility of CCACs and Care Coordinators. ONA currently represents 3,200 members at 10 of the 14 CCACs in Ontario.

Fortunately, the RNAO’s recommendation has not received much uptake from the MOHLTC thus far. In fact, the Ontario budget released in May allocated a one-per-cent increase for community and home care on top of the four-per-cent funding allocated in the 2012 budget.

This signals that there is at least recognition from the government that it needs to fund the community sector appropriately if it continues to shift more and more services out of hospitals.

At the same time, the budget freezes funding for the hospital sector. This creates additional pressure on CCACs as they try to deal with patients, who are being sent home earlier and sicker and therefore require more acute care. (See story “Community Care Funding Boost” on page 3 for more information.)

The RNAO’s Enhancing Community Care for Ontarians (ECCO) report assumes that four million more hours of home health care and support services would be added if the MOHLTC closed down the CCACs, by eliminating

Challenges in the CCAC Sector

The main areas of concern for our CCAC members are:
- Work realignment and new models of care with re-focusing of CCAC work.
- Workload issues resulting in a risk to the quality of care and a failure to meet professional standards.
- Services being contracted to non-ONA providers.
- Changes in the delivery model threaten the loss of Bargaining Unit work.

Workload Issues

Our members are experiencing heavy workloads, particularly with the introduction of new models of care in CCACs, and are utilizing the Professional Responsibility Complaint (PRC) process to document situations they feel are putting clients at risk and compromising professional standards.

For Profit vs. Non-Profit

More and more, CCACs have been contracting with for-profit companies to provide community-based care, which is resulting in non-profits like the Victorian Order of Nurses (VON) losing volumes of work and/or contracts.

At one CCAC for instance, the VON contract was discontinued in favour of a for-profit company, resulting in the loss of some 34,000 hours of experienced community nursing care.

In this scenario, the quality of care is compromised because for-profits hire less-experienced caregivers and pay them less than their more experienced counterparts. Also at stake is the continuity of care. Introducing a new caregiver requires a period of adjustment for both the client and care provider.
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**FROM COVER**

“costly duplication” and integrating services. The report recommended that CCAC Care Coordinators move into primary health organizations, such as general practitioner offices, Nurse Practitioner (NP)-led Clinics, Family Health Teams (FHTs) and Community Health Centres (CHCs). The report suggested some of the responsibilities of CCACs could be transferred to Local Health Integration Networks (LHINs), which were actually set up to manage and fund CCACs and other health services in communities.

**ECCO Plan Unworkable**

ONA takes great issue with the RNAO plan presented in its ECCO report, and has completely rejected the recommendation.

“The government’s focus of moving care out of hospitals and into the community makes this the ideal time to expand and enhance the role of CCAC Care Coordinators, as well as Registered Nurses (RNs) and Allied Health Professionals, who provide invaluable services and care to the community,” said ONA President Linda Haslam-Stroud, RN.

“The wholesale closure of CCACs is a backward step, attempting to fix what is not broken. Instead, it will increase pressures on an already overburdened primary care system, and in fact will make it harder for patients to access home care.”

Haslam-Stroud says the MOHLTC needs to undertake a critical review of the size and cost of management staff, noting that CCAC administration costs are extensive, even after amalgamating Ontario’s 42 CCACs into 14 after restructuring the health-care system to formulate the LHINs system.

“Maximizing the resources of front-line professionals and minimizing the cost of administration will ensure our health care dollars flow to where they are most beneficial, our patients, residents and clients.”

**Labour Implications**

Should the RNAO recommendation be implemented, it would be the third major restructuring in this sector since 1996. The impact on workers of this massive change and the resultant stress is incalculable, from a psycho-social and financial standpoint.

There are also numerous labour implications involved that will directly impact ONA members working in the health-care system, as follows:

- **Closure of the CCACs** will result in the mass transfer of workers throughout the health-care system.
- **The Public Sector Labour Relations Transition Act (PSLRTA)** will apply to the movement of workers, except those who work in public health and doctors offices, unless the legislation is changed.
- **There would be representational votes with other unions and many non-union environments, which can be resistant to unionization, to determine who will represent the workers under the Ontario Labour Relations Act.**
- **Movement of ONA members would be to the following areas:**
  - Primary care organizations, such as Community Health Centres (CHCs), Family Health Teams (FHTs), Aboriginal Health Access Centres and NP-led Clinics: This would include Health Connectors, care coordination, discharge planning, system navigation and ordering home-care services.
  - LHINs: Coordination of services and long-term care (LTC) placement. This is not covered under PSLRTA legislation.
  - Hospitals: Includes discharge planning. Hospitals are currently moving discharge planning to CCACs and ONA has a number of PSLRTA files open on this issue.
  - Home care agencies: Includes delivering home-care services (i.e., RNs, Registered Practical Nurses [RPNs], physiotherapy and occupational therapy). Rapid Response Nurses, NP integrated palliative care and coordination of dressing and other supplies (this affects our allied Bargaining Units).
  - Public health: Pediatric Mental Health Teams (new school positions).

This just touches the surface of the vast implications for ONA members and Ontario’s community care system should the RNAO recommendation be accepted.

ONA is working tirelessly to support our members, including Care Coordinators and Allied Health Professionals working in CCACs, as Ontario reforms its health-care system. We will continue to meet with the government and advocate on our members’ behalf to ensure their rights are protected and that they are able to provide quality care.

In the next few pages of this special feature section, read about what CCACs actually do. You will also read about some of the challenges our members face in their jobs.
Community Care Funding Boost, But at What Price?

The Ontario 2013 budget released in May froze funding for the hospital sector and allocated an increase for community and home care.

The budget added an additional 1 per cent per year to the 2012 budget, which means that over the next three years, there will be an average 5 per cent annual increase to home and community care services.

That will bring about $700 million in new funding to the community sector by 2015-16 ($260 million in 2013-14).

The government claims this funding will reduce wait times for patients, and help set a target for those who require nursing services and patients with complex needs to receive home care within five days of their Community Care Access Centre (CCAC) assessment.

While this may signal a greater commitment by the Ontario government to bolster community and home care resources as it seeks ways to shift more and more services out of hospitals, the price tag might be too great for Ontarians.

ONA believes the bad news for hospitals will result in further cuts to hospital services, specifically a further “gutting of front-line RN care,” says ONA President Linda Haslam-Stroud, RN.

“The cuts being made to hospitals as the government seeks to reform health care will negatively impact the quality of care and will hurt patients. We’ve already been through several years of what amounts to budget cuts, which have resulted in the loss of hundreds of nursing positions,” said Haslam-Stroud.

“For the sake of patient safety, this has got to stop. Our hospitals need stability and these cuts will leave patients seeking any hospital-based acute nursing care they may need that simply can’t be found in the community.”

Increased funding for community and home care, while a positive step for that sector, should not come at the expense of hospital programs, beds and RN care, said Haslam-Stroud. Numerous scientific studies have shown there is a seven-per-cent increase in patients suffering complications and/or death when there are too few RNs caring for too many patients.

In addition, discharging patients from hospitals earlier creates additional pressures on an already overburdened community system, as CCACs try to cope with patients who still require acute care.

“The Ontario government seems to be moving away from a fully public health-care system by directing more tax dollars to for-profit providers in the community,” said Haslam-Stroud. “That leaves patients with nowhere to go when they require the kind of care that can only be provided by hospitals.”

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Challenges in the CCAC Sector

Outcome-Based Pathways

Outcome-Based Pathways (OBP), a pilot project until the fall of 2013, is a method of care/service delivery relying on best practices, business efficiencies and treatment innovations.

Pathways currently available are 10 for wound care, one for hips and one for knees. Palliative care has three pathways.

OBPs are ordered by the CCAC at the time of service offer or requested by a CCAC-contracted service provider during provision of care.

This is one of the most significant challenges to our members’ security in the CCAC system. ONA is concerned that OBP may eventually be used to eliminate Care Coordinators work, and will impact negatively on quality client care and outcomes. ONA continues to monitor and track the work of our members in this area to ensure Bargaining Unit work is not being moved to primary care organizations such as Community Health Centres (CHCs) and Family Health Teams (FHTs).

In some cases, CCACs are placing Care Coordinators employed by the CCAC directly into CHCs and FHTs, but this work remains in our Bargaining Units.

Client Care Model

CCACs have moved to the Client Care Model (CCM) intended to improve coordination and care transitions for clients requiring community health and social services.

The CCM assumes it will empower people to self-navigate their own care, on the presumption that a “one size fits all” approach is inadequate. The CCM provides care based on evidence-based population, with a targeted population of complex, chronic, community, independent, short-stay and well clients.

The downside is our members are reporting that their workloads are excessive and vary greatly across the province. Some CCACs are doing a better job of supporting and listening to their staff than others.

Client Health Related Information System (CHRIS)

CHRIS is the case management information technology system designed to give CCAC Care Coordinators and Administrators a common system to enter and track patient information and service plans across Ontario.

Through what is referred to as the Health Partner Gateway (HPG), which was also developed for the CCACs, CHRIS is able to link electronically with the many health care service providers across the province who deliver nursing and personal support services.

CHRIS is now fully implemented across the CCAC system, but is currently still unable to automatically enter information across duplicate fields when inputting information.

ONA has raised the concern that the random assignment of services by CHRIS with no consideration for geography/location and/or provider has created workload issues for our members.

Concerns have also been raised re: non-health professionals completing health assessment sections of the InterRAI CONTACT Assessment tool for client information intake (RAI is the Resident Assessment Instrument). The issue has been resolved at some CCACs, whereby Care Coordinators, who are professionally accountable for health assessments, are now completing these sections.
CCACs: “Constant Change and Chaos”

Dianne Leclair
Care Coordinator, Hamilton Niagara Haldimand Brant CCAC
Vice-President Region 4 and Chair, CCAC Network

Dianne Leclair, RN, says “CCAC” really should stand for “Constant Change And Chaos.” It’s a definition reflective of the kind of environment ONA members working at 10 of Ontario’s 14 Community Care Access Centres (CCACs) find themselves in, she says.

“As a Care Coordinator, I’ve seen numerous changes over the years, including system restructuring and policy changes. Care Coordinators experience this on a daily basis and are routinely told about different funding problems and different funding models,” says Leclair.

“There are so many policies and hoops to jump through in my day-to-day work, that I often don’t feel I can provide the best possible service for my clients.”

Workload is one of the top issues for CCAC Care Coordinators, says Leclair, who works at Niagara Health System sites as an employee with the HNHB CCAC.

With hospitals discharging patients into the community earlier because of their own budget pressures, Care Coordinators are dealing with sicker clients who require a greater level of care. “There simply isn’t adequate funding or services in place in the community to ensure they get the care they need, and wait lists for home care support, long-term care beds and supportive housing adds to the overwhelming pressure,” she says.

It results in a very challenging work environment for the Care Coordinators and Allied Health Professionals. “We are trying to provide the best client-focused care, but the workload is causing burnout, stress and increased sick time for CCAC workers,” says Leclair.

CCAC Care Coordinators are being encouraged to utilize the professional responsibility process to document excessive workloads and caseloads, and record situations where the safety of patients, residents and clients are at risk.

Still, despite the pressures, Leclair says she has the best of both worlds, as an ONA leader and also as a front-line Care Coordinator. “In my role as the Chair of our CCAC Network and as a Board member, I work hard to make sure our membership understands the role of the CCAC, and that our members in the CCAC sector know we are there for them. It’s also so important to ensure that our clients and their families, as well as the government, understand our role,” says Leclair.

“And in my role as a Care Coordinator, I find it so rewarding to be able to ensure our patients can be discharged into the community safely. Whether it’s to their own homes or into a long-term care facility, I just want to ensure they receive quality care and are safe and comfortable. That’s my number one goal.”

Care Coordinators: The Challenges and Rewards

ONA Care Coordinators talk about the difficulties they face in their work, and what they find most rewarding.

Caroline McWhinney
South West CCAC
Bargaining Unit President and Member, CCAC Network

Challenges: “The complexity of care requirements for clients receiving services in the home has increased dramatically. For our clients with multiple healthcare needs, we are the ‘go to’ person to help them navigate the systems, however caseloads remain too high to provide the care coordinator the ability to support their clients. Anticipated huge growth in requests for services to support clients in their homes will only increase caseloads with the aging population.”

Rewards: “Supporting clients to remain in their homes either with services through the CCAC or linking with community agencies is rewarding. Whether it is a family supporting a medically fragile child, a palliative client who wishes to die at home or remain there as long as possible before admission to a palliative unit, or supporting seniors in home with services until future transition to a long-term care home if needed, I know my clinical knowledge and experience as a Care Coordinator has provided my clients the support needed to make their decisions.”

Louise McNeil
North East CCAC
Bargaining Unit President and Member, CCAC Network

Challenges: “For the north, we do have resource challenges whereby our service providers cannot always keep up with the demands. Trying to provide the best care to an increasingly complex aging population has become a daunting task for Care Coordinators.”

Rewards: “It is so rewarding when it all comes together, despite the hurdles. When Care Coordinators are able to arrange for the care that gets the client home from hospital and keeps that client in their home for as long as possible, that is a success.”

Sandra Ryder
North West CCAC
Bargaining Unit President/Local 14 Coordinator and Member, CCAC Network

Challenges: “The pressing need to reduce hospital ER visits, admissions and length of stay, including Alternative Levels of Care (ALC) time, has placed great demands on the Care Coordinators to help clients return home and remain safely at home. In many cases, for a successful transition from hospital to home, this means that home care and community services, as well as family and primary care supports, all need to be in place. It’s a complex job, and clients as well as health-care providers look to us for our expertise in making this happen.”

Rewards: “It’s all about meeting the unique needs of our clients. For the person with mobility problems, it may mean having a scooter to get to the grocery store. For the tired caregiver,
Care Coordinators Steer Clients Through a Complicated System

Ann Rowley
Care Coordinator, Central East CCAC
Bargaining Unit President and Member, CCAC Network

Ann Rowley, RN, sees CCAC Care Coordinators as the navigators of a complicated and cumbersome system that help steer clients from hospital to home “and all the stops between.”

“As a nurse I feel responsible to have the knowledge and be able to give correct and timely information to clients, families, physicians and the community, as that is what they want and need. My members need to access to the same information too. I have to stay on top of that through a challenging communication process of email and videoconferencing. It’s next to near impossible.”

The overriding concern for her members is their professional responsibility to the College of Nurses of Ontario (CNO) and their ability to meet the standards of care in this current challenging climate, says Rowley.

“I’ve encouraged my members to document their workload concerns and they have started to do this. They used to be a little resistant, but now they do it. Why? Because they are fearful that they could lose their licenses and lifelong careers if they can’t meet their professional responsibilities,” she says.

“I emphasize that it’s also a way of protecting themselves when they have in writing that they notified their superiors of issues, suggested possible solutions and shown they are eager to work with the employer to address the problems,” says Rowley.

So far, the employer is reacting to the complaints, but only applying band-aid solutions instead of systemic change, she says.

“We have 22 vacancies but our employer is not concerned because it meets the provincial and industry standards. We had a hiring freeze and cost containment policy until April 1, 2013, which means we are not providing adequate service. The government is not funding CCACs appropriately, and this is clearly an issue for our clients,” said Rowley.

“My members are always putting the clients first. The challenges and barriers we face on a daily basis can sometimes feel insurmountable. The system needs to change, but not by adding more bureaucracy, by adding more RNs and Allied Health Professionals to the system. Ontarians deserve a better system and the CCAC Care Coordinators can lead that system into the future.”

The pressures are sure to mount in the fall when new programs roll out from the Ministry of Health and Long-Term Care, adds Rowley.

it may mean some respite services. And for the person in end-stage disease, it may mean having the supports in place to die at home with family at their side.”

Suzanne Gelinas
Erie-St. Clair CCAC
Bargaining Unit President and Member, CCAC Network

Challenges: “Underfunding the community results in Care Coordinators carrying heavy workloads and patients needing more services than the CCACs can supply. This makes for a daily challenge for the pressured hospital and CCAC staff, who work tirelessly as a team to ensure our patients’ safe transition home. Once home, the key to long-lasting stability is CCAC services, which require more funding to meet the Ontario provincial commitment to have our patients live or die in their homes.”

Rewards: “When we work together (patient, family, CCAC Coordinators and hospital staff), it feels like we are fitting together the pieces of a jigsaw puzzle. After trying all the different options, the pieces finally fit and the patient is happily home. The feeling of warmth for a job well done sends the Care Coordinators on to try again for the next patient and the next, and the next …”
CCACs: Access Point to Community Care

Sources: Ministry of Health and Long-Term Care; Ontario Association for Community Care Access Centres.

Community Care Access Centres (CCACs) are local agencies that co-ordinate community health services for seniors, people with disabilities and people who want to live independently in the community but require support, either in their own homes, specialized housing or in long-term care facilities.

The access point to Ontario’s community services and long-term care system, the province’s 14 CCACs assess clients’ needs and determine their requirements for care. Working with physicians, hospital teams and other health-care providers, CCAC Care Coordinator/Case Managers develop personalized plans for the delivery of a full range of in-home and community-based services, such as:

- Professional care, i.e., nursing, occupational therapy, physiotherapy, social work, speech therapy and dietetics.
- Personal support and homemaking, i.e., assistance with daily living, such as personal care.

Depending on need, referral to and coordination with community support services, such as Meals on Wheels, transportation and/or home cleaning, may also be required.

CCACs assess a client’s needs, determine requirements for care, answer questions and develop a care plan that meets individual needs by:

- Coordinating visiting health and professional services in people’s homes
- Coordinating school health support services for children
- Arranging admissions to certain adult day programs, supportive housing and assisted-living programs,

chronic care and rehabilitation facilities, and to all long-term care facilities.

- Providing information and referrals to the public about other available community agencies and services.
- Coordinating services such as nursing, physiotherapy, occupational therapy, speech-language therapy, dietician services, pharmacy services, diagnostic and laboratory services, respiratory therapy, social work, personal support and homemaking.
- Determining eligibility and making arrangement for admission to day programs, supportive housing/assisted living programs and to chronic care and rehabilitation beds, and to all long-term care facilities.

Working with other health care professions, CCACs:

- Help people to spend less time in hospital and more time at home recovering.
- Prevent unnecessary emergency room visits.
- Facilitate placement to long-term care homes or other alternate care facilities.
- Help people to continue to live in their own homes and communities as they age or cope with long-term health problems.
- Facilitate those who are dying to stay and be cared for at home.
- Facilitate those who have short-term rehabilitation needs return to work or school.

The 14 CCACs across Ontario are funded by Local Health Integration Networks (LHINs) through the Ministry of Health and Long-Term Care (MOHLTC). CCACs operate in several branch and site offices aligned to their LHIN geographic boundaries. The 10 listed below are ONA Bargaining Units.

1. Central
2. Central East
3. Erie-St. Clair
4. Hamilton Niagara Haldimand Brant
5. North East
6. North West
7. North Muskoka Simcoe
8. South East
9. South West
10. Waterloo Wellington

ONA members from the Central CCAC
Job Classifications Within CCACs

Care Coordinators (Case Managers)

Many ONA members working at CCACs are Care Coordinators, who can be both RNs and Allied Health Professionals. Their primary role is to assist clients and their families/care providers navigate through the complexities of the health-care system. They assess risks, identify priorities, design service plans, monitor for continuing eligibility and manage a diverse mix of caseloads. They also mediate conflicts between clients and service providers.

In the community, Care Coordinators conduct face-to-face assessments in clients’ homes and work to connect clients to available or alternative resources in the community.

Working on site at a hospital, Care Coordinators interact directly with physicians, patients, families and members of the multidisciplinary hospital team. They provide bedside patient assessments and may either expedite the patient’s discharge into the community or advocate on behalf of patients for whom returning home would not be safe. They may also attend multidisciplinary patient rounds and participate in hospital committees and/or orientation as a CCAC representative.

In the CCAC office, Care Coordinators focus on triaging telephone referrals and time-sensitive client service requests, and respond to information and referral needs. On occasion, they may also be responsible for researching and developing information and referral resources for staff and clients. Care Coordinators in the CCAC office help facilitate a quick response to the needs of clients and service providers.

ONA Specific Roles

ONA represents a large array of professionals providing support at CCACs. Professional Bargaining Units are comprised of RN Care Coordinators, Mental Health and Addiction RNs and RPNs, Nurse Practitioners and other classifications.

In all-employee Bargaining Units, ONA members include Resident Assessment Instrument (RAI) Coordinators, who develop resident-focused care plans in long-term care, discharge planners, waitlist planners, placement facilitators, placement admissions/admissions coordinators, who authorize admission into long-term care homes, contract coordinators, schedulers, quality improvement analysts, health records technicians, community relations specialists, clerks, payroll/accounts payable clerks and system analysts.

Additional Nursing Positions

CCACs expanded to include 340 permanent nursing positions beginning in January 2012 as follows:

- Five nurse practitioners (NPs) to support CCAC palliative clients in the home and to build capacity for 24/7 palliative care, support death in the home where appropriate, improve pain and symptom management and reduce hospital admissions. This program created 120 RN positions.
- RNs positions were created for a Rapid Response Nursing Program to better support the transition from hospital to home and reduce Emergency Department use, prevent hospitalization and readmission by having the RN visit in the home for eligible clients within 24 hours of hospital discharge, and ensure a plan of care is in place for the first few days at home. This program created NP, RN and RPN positions.
- Mental Health Addiction nurses in district school board programs were added to complement the existing roles of CCAC Care Coordinators, contract service providers, school board staff and other partners. Expected outcomes include improved client experience and well-being, as well as reduced avoidable hospitalization, emergency department visits and Alternative Levels of Care (ALC) days. This created 131 RN/RPN positions.

CCACs by the Numbers

Source: Ontario Association of Community Care Access Centres

Each year, Ontario’s 14 Community Care Access Centres (CCACs) care for more than 600,000 people, including 300,000 seniors, providing information, direct access to qualified care providers and community-based services to help people move from hospitals to the community or live independently at home.

In 2011-12, more than 637,000 people utilized CCAC services, including:

- 517,965 patients receiving home care.
- 79,226 children receiving health-care services in schools.
- 98,000 people accessing long-term care homes.
- 25,680 patients receiving palliative care at home.

Services covered:

- 23 million hours of personal support.
- 6 million nursing visits.
- 2 million hours of shift nursing care.
- 1.3 million visits from therapists and other allied health providers.
From Case Manager to Care Coordinator – More than Just a Name Change!

Ontario’s 14 Ontario Community Care Access Centres (CCACs) are now using the title “Care Coordinator” for the work provided for many years by the “Case Manager.”

The name change more appropriately reflects the client-focused care of CCAC Care Coordinators in coordinating the health care and support services required by their patients, residents and clients, rather than the more administrative-sounding function implied by the former name.

“The title Care Coordinator is much more reflective of the work we do,” says ONA Region 4 Vice-President Dianne Leclair, a CCAC Care Coordinator who chairs ONA’s province-wide CCAC network.

“The role of the Care Coordinator encompasses much more than dealing with ‘files’ and managing tasks. It is not an administrative role. It is a role that deals directly with the assessment of health-care needs and requirements of clients following discharge from hospital to their homes, long-term care facilities or supportive housing.”

Care Coordinators help clients remain safely in their home through assessments, ensuring they are receiving appropriate services. They also provide clients and their families the information they need to make informed decisions about going into long-term care facilities or supportive housing. As well, they ensure that school children with medically complex needs or mental health issues can attend school daily.

“As Care Coordinators, we require an in-depth knowledge of all components of the health-care system and an ability to liaise between the various services for the best possible outcome for the patient, client or resident,” says Leclair.

“While the name may have changed, the work we do remains the same. We have a vital role within the whole health-care system and need to ensure our communities and the government know that.”

Hamilton Niagara Haldimand Brant CCAC members.