

Independent Assessment Committee Report

Constituted under Article 24 of the  
Collective Agreement between

Erie St. Clair Community Care Access  
Centre  
And  
The Ontario Nurses' Association

July 10, 2014

**Erie St. Clair Community Care Access Centre (ESC CCAC)  
And  
The Ontario Nurses' Association**

Lori Marshall  
Chief Executive Officer  
Erie St. Clair CCAC

Rozanna Haynes  
Professional Practice Specialist  
Ontario Nurses' Association

The members of the Independent Assessment Committee (IAC) have concluded our review and respectfully submit this report of our findings and recommendations in accordance with section 24 of the collective agreement between the Erie St. Clair Community Care Access Centre (CCAC) and the Ontario Nurses' Association (Association) at a hearing held on June 17-19, 2014 in Windsor, Ont.

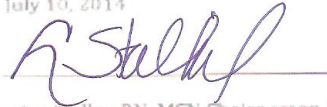
The Independent Assessment Committee is appreciative of the time and effort of all of those who attended the hearing, and/or assisted with the preparation and presentation of the material for the hearing. The committee also appreciates the time of those who answered questions about the professional responsibility complaints (PRC), during the tour and during the hearing.

The process undertaken through an Independent Assessment Committee allows for an opportunity for discussion and dialogue between both parties in regards to the concerns and conditions brought forward in the Professional Responsibility Complaints. The IAC has made 32 recommendations in 9 key areas regarding issues that impact either directly or indirectly, the Professional Practice Concerns of the Registered Nurses, who represent 90% of the Care Coordinators employed at the CCAC. The recommendations are in the areas of:

- Model of care
- Morale
- Staffing
- Workload/scheduling
- PRC (Professional Responsibility Complaint) process/Communication
- Role Clarity
- Scope of Practice
- Event Tracking Management System (ETMS)
- Staff Morale

The attached report contains the unanimously supported recommendations from the IAC that we hope will assist all parties to find mutually agreeable resolutions to the workload concerns at the Erie St. Clair CCAC.

Respectfully submitted on July 10, 2014

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Laralea Stalke RN, MSN Chairperson IAC

A handwritten signature in brown ink, appearing to read "Sheila Gingras", written over a horizontal line.

Sheila Gingras RN, ONA Nominee

A handwritten signature in brown ink, appearing to read "J. Taciuk", written over a horizontal line.

James Taciuk RN, CCAC Nominee

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## **Section 1: Introduction**

### **1.1 Organization of the Independent Assessment Committee (IAC) Report**

The Independent Assessment Committee Report is presented in five parts:

#### **1. Introduction**

This section outlines the referral of the professional practice complaints to the IAC, reviews the IAC's jurisdiction as outlined in the Collective Agreement between the Erie St. Clair CCAC and the Ontario Nurses' Association, and summarizes the Pre-hearing, Hearing, and Post-hearing processes.

#### **2. Presentation of the Professional Responsibility Workload Complaints**

Presents the context of practice and understanding of the professional practice complaints (PRC) from the Erie St. Clair CCAC ONA members; summarizes the relevant history leading to the referral of the professional practice complaints to the IAC; and reviews the presentations by both the Ontario Nurses' Association (Association) and the Erie St. Clair Community Care Access Centre (CCAC) at the hearing.

#### **3. Discussion, Analysis, & Recommendations**

Presents the IAC's analysis and discussion of the issues relating to the PRC's.

#### **4. Summary and Conclusions**

Presents the IAC's conclusions and recommendations.

#### **5. References and Appendices**

Contains the Appendices referenced throughout the IAC report.

The submissions and exhibits of both ONA and the Erie St. Clair CCAC are on file with both parties.

## 1.2 Jurisdiction of the Independent Assessment Committee

The IAC is governed under section 24 of the Collective Agreement between the CCAC and the Association. Article 24 of the Collective agreement outlines the grievance and arbitration procedure.

Article 24 of the Collective Agreement reads as follows<sup>1</sup>:

- 24.01        The parties agree that client care is enhanced if concerns relating to professional practice are resolved in a timely and effective manner.
- When meeting with the Manager, the Employee(s) may request the assistance of a Union representative to support/assist her/him at the meeting.
- 24.02        The following principles shall govern the resolution of issues:
- (a)        The parties will utilize a problem-solving process focusing on collaborative solutions at the earliest possible opportunity.
  - (b)        Circumstances arising more than six (6) months prior to the issue being raised with the Employee's Supervisor shall not be considered unless a pattern has been established.
  - (c)        It is understood that professional practice/workload issues do not constitute a difference between the parties as to the interpretation, application, administration or alleged violation of the provisions of the Collective Agreement and, accordingly, are not subject to Article 8 (Grievance and Arbitration Procedure).
- 24.03        The following process shall be followed:
- (a)        In the event that a professional practice or workload issue arises that affects an individual Employee or a group of Employees, such that there is cause to believe that they are being asked to perform work of a quality, or in a manner, that is inconsistent with applicable professional standards, the Employee(s) shall discuss the issue with their Manager or designate within five (5) working days of the issue arising. If the issue remains unresolved, the

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<sup>1</sup> Collective Agreement between ESC-CCAC and ONA, expiry March 31, 2014.

Employee(s) shall within five (5) work days document their professional practice issue in writing (using the form set out in Appendix 2) and forward it to their Manager.

- (b) Within ten (10) workdays of receiving a form, a meeting to discuss the professional practice issue shall be held with the Employee(s), a Union representative, the Manager, and the Senior Director, Client Services and/or designates. Within five (5) workdays of the meeting, a written response shall be provided to the Employee(s) with a copy of the response provided to the Bargaining Unit President. The parties may mutually agree to proceed directly to (c) below.
- (c)
  - i) Failing resolution of the complaint within fifteen (15) calendar days of the meeting of the Union-Management Committee, the complaint shall be forwarded to an Independent Assessment Committee composed of three (3) persons who have expertise in either Case Management, In-Home Services or Long Term Care Coordination Services, depending on the type of complaint filed; one (1) chosen by the Union, one (1) chosen by the Employer, and one (1) chosen by the other two (2) from a panel of two (2) independent Registered Nurses who are well respected within the profession. The member of the Committee chosen from the panel shall act as Chairperson.
  - ii) The Assessment Committee shall set a date to conduct a hearing into the complaint within thirty (30) calendar days of its appointment and shall be empowered to properly assess the merits of the complaint. The Assessment Committee shall report its findings in writing to the parties within thirty (30) calendar days following completion of its hearing.
- d)
  - i) The list of Chairpersons – Assessment Committee is attached to and forms part of this Agreement.
  - ii) Each party will bear the cost of its own Nominee and will share equally the fee of the Chairperson and whatever other expenses are incurred by the Assessment Committee in the performance of its responsibilities as set out herein.



- e) Any complaint lodged under this provision shall be on the form set out in Appendix “2” of this Collective Agreement. The parties may agree to an electronic version of the form and a process for signing.
- (f) At any time during this process, the parties may agree to the use of a mediator to assist in the resolution of the issues arising out of this provision.
- (g) Timelines outlined in the above article can be extended by mutual agreement of the parties.

### **1.3 Referral of the Professional Responsibility Complaint to the IAC**

The Care Coordinators (CC’s) at the Erie St. Clair (ESC) CCAC began to document their concerns regarding their workload and practice issues in 2011, on Professional Responsibility Complaint forms (PRC’s). The CCAC management team and ONA members met in regards to these PRC’s on several occasions, but were unable to reach a consensus on how to address their concerns. In a pre-hearing meeting between ONA and the ESC-CCAC, it was agreed the IAC would address strictly those PRCs’s from January 1, 2013 to May 20, 2014.

In April 2013 a Labour Relations Officer, was assigned to assist with the PRCs’s and due to no resolution at that time, a Professional Practice Specialist was assigned in August 2013(see appendix A). There were two ONA/Management PRC resolution meetings in 2013 and one in 2014 with very few resolutions to date. There were 66 PRC’s filed by the Care Coordinators in 2013, and 8 ONA/Labour Relations Management meetings in 2013. It is important to note that the PRC’s were not discussed at every ONA/Labour Management meeting. The IAC Chair was sent a letter on November 20, 2013 to request confirmation of a hearing in regard to professional practice from the perspective of being unable to provide safe, ethical care in and nursing practice setting”. See Appendix B.

The year 2013 was a year for major change for the Erie St. Clair CCAC with the implementation of the Client Care Model (CCM). On or about January 7, 2013, the CCAC began the CCM formally. There had been a memorandum of agreement signed between ONA and the CCAC on October 18, 2012 to conduct a “mass layoff/bumping” selection process, in order to implement the model. This process of “layoff/bumping” was implemented between October 30-Nov 7, 2012. This did not result in any CC’s being permanently laid-off from the CCAC.

The IAC jurisdiction thus relates to the dispute between the Erie St. Clair CCAC as the employer, and the ONA members, who feel the provisions of the Collective Agreement, are being violated. The IAC is responsible for examining factors that impact workload and professional practice, and make recommendations to address those particular issues.

Concerns outside of workload and professional practice are beyond the jurisdiction of the IAC.

In the matter of the arbitration between the Erie St. Clair CCAC and the Ontario Nurses' Association, the IAC will have authority to "only settle disputes under the terms of this agreement and only to interpret and apply this agreement." The IAC will provide an independent, external perspective to assist both parties to achieve mutually agreeable resolutions to their concerns. The IAC is not an adjudicative panel, and its recommendations are not binding. The jurisdiction ends with the submission of this report. All members of the IAC are Registered Nurses. The member for the Association was Sheila Gingras, for the CCAC, James Taciuk, and the Chairperson, Laralea Stalkie.

## **1.4 Proceedings of the Independent Assessment Committee**

### **1.4.1 Pre-Hearing**

On August 13, 2013, the Association notified the CCAC that the PRC's were being sent to an IAC in a pre-complaint letter. The IAC committee Chair was contacted by the Association on November 20, 2013, the same day the ONA nominee was given Exhibit 5 ONA (see appendix C. The Erie St. Clair was sent an email requesting their nominee on January 21, 2014, as it had not yet been received. Their nominee was confirmed on January 23, 2014 (see appendix D).

### **1.4.2 IAC Introductory teleconference**

On January 23, 2014, the Chair of the IAC contacted via email the Association and CCAC nominees to set the first meeting of the committee. The IAC met by teleconference on January 30, 2014 and discussed the following:

- Overview of the IAC process and timelines;
- Proposed dates for the hearing;
- Information requirements for the committee to assist in its process and deliberations.

### **1.4.3 Hearing confirmation and Hearing distribution**

On January 30, 2014 the IAC Chair proposed dates to the CCAC and the Association for April and May 2014. These dates were not agreeable to both parties and on Feb 13, 2014 the date for June 17-19 was confirmed for the Hearing. Due to spacing and travel time to sites, it was agreed on March 7, 2014 to convene at the Holiday Inn in Windsor, Ontario.

On February 18, 2014, the IAC Chair communicated by email with the Association and the CCAC with regards to the requirements of the Hearing submissions and distribution of materials to be submitted to the IAC Chair on Friday May 30, 2014. On May 26, 2014 legal

Council for the CCAC requested an extension for their Submissions until June 4, 2014. The date of June 5, 2014 was given by the Chair and agreeable to all parties.

On April 9, 2014 a revised agenda for the hearing was sent to both parties and the IAC, outlining the 3-day hearing.

On June 1, 2014, the IAC Chairperson was notified the ONA tour participants would be Rozanna Haynes (ONA Professional Practice), Cathy Bourque (Care Coordinator-Community), and Marsha Sparnaay (Care Coordinator-Intake). On June 2, 2014, the IAC Chairperson was notified the tour participants for the CCAC would be: Trisha Khan (Senior Director of Patient Services), Lucy Coppola (Director Patient Services), and Cheryl Zaffino (Patient Service Manager).

The IAC Chairperson received the briefs from both parties on June 5, 2014 at the end of day. On June 6, 2014 the ONA brief was couriered to Nancy Jammu-Taylor, legal council for the CCAC and the CCAC submission was sent to the attention of Rozanna Haynes at the Ontario Nurses' Association. The IAC committee nominees from both ONA and the CCAC were also couriered brief submissions on that same day.

#### **1.4.4 Pre-Hearing Meeting of the IAC**

The IAC held a pre-hearing meeting at the Holiday Inn, Windsor, ON, on Monday June 16, 2014. At this meeting the IAC discussed:

- The process for the hearing;
- A review of the submissions from both the CCAC and the Association;
- The themes from both the Association and the CCAC submissions that emerged from the pre-hearing briefs and exhibits;
- Identified key areas to visit on the tour of the CCAC to be arranged for June 17, 2014;
- Determined questions that the IAC had on the submissions that were submitted in writing prior to the hearing;
- Identified key questions on issues/concerns that needed to be clarified or explored over the hearing.

#### **1.4.5 Site Visit**

The tour of the Erie St. Clair began at 1000 on June 17, 2014 in the Windsor site of the CCAC Community Nursing clinic. The clinic has recently been opened at this site and is being staffed by a CCAC Nursing Team Assistant (TA) for clerical duties and the clinic duties are being performed by the Bayshore Nursing Agency. There are no PRC's associated with the clinic therefore, there will be no further description of this part of the tour.

The tour of the CCAC began shortly thereafter and it was apparent to the IAC that there were several ONA members, who were eager to speak to them about their current

professional practice concerns, some of which will be noted here. The tour gave the IAC an overview of the actual physical layout of the CCAC and the work areas of the Care Coordinators in both the Intake and community areas, where specific PRCS's had been filed.

The IAC toured the entire CCAC site of the spacious Windsor office, with many cubicles of desk space. It was noted by the IAC that there was a large area of unused desks in the middle of the office at the present time. Management informed the IAC that there would be "plans" for them in the future, but there was no divulgement of further information. It was also apparent that many desks were unstaffed and CC's were eager to point out that that some of this was due to CC's being out on home visits, and others were "covering other work areas."

The "Intake" area was considerably noisier than the rest of the office presumably due to the amount of phone calls being received at any given time during the workday. The Information and Client Resource Service Team Assistants (ICR-TA) in Intake are separated from the Intake Care Coordinators, by a half wall partition. The management's reasoning behind the half wall partition being erected, was to assist in the "elimination of some of the noise level in and around the Intake area and to increase productivity".

However, this physical barrier between the ICR-TA's and the CC's is a contentious subject with ONA members. The existence of the wall seems to have increased the tension levels between the two professions from ONA's point of view and adds to the culture of silos that seems present. The CC's repeatedly stated the value of the TA's working alongside the CC's at the CCAC, and this barrier hinders the ability to "function as a team".

The tour allowed the IAC to view the Intake area and have discussions with the Community CC's, who shared their concerns about the lack of consistent coverage at their desks to manage patient caseloads. The CC's expressed that this hindered their ability to perform home visits to their patients to complete their Resident Assessment Instrument (RAI) and to initially assess or reassess the patients care requirements. The CC's who spoke to the IAC, all mentioned how they felt they were unable to meet their patient's care needs, with their current workloads and working conditions due to inconsistent desk coverage. The CC's also shared that the ONA representative from the CCAC, who was participating in the tour and being compensated by the Association for the day, had not be replaced at her desk, as a requirement of the Collective Agreement, article 6, section 6.04.<sup>2</sup>

Management shared that the level of absenteeism in some teams is extremely high, which hampers their ability to fully staff in some areas. In one team, it was noted that every day there are 1.63 staff members absent. Thus, Management stated they relied heavily on their Float CC's to provide the necessary coverage.

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<sup>2</sup> Collective Agreement between the ESC-CCAC and ONA, expiry March 31, 2014.

The process of Geo-coding and patient classification was explained to the IAC for clarity to how this system impacts on the Care Coordinators caseload assignment. Classification of the patient and their geography are taken into account in an effort to equalize caseloads.

Due to the number of PRC's concerning the role of Team Assistants, the IAC questioned if there were joint staff meetings in the teams with both TA's and CC's. It was explained that there were monthly general meetings for the CCAC and there were also monthly team meetings. It was suggested that the TA's and the CC's do not consistently have integrated meetings in some teams. It was also mentioned that the TA's and the CC's have different managers to report to, which again creates the culture of separate entities, within the organization. The IAC inquired if the staff had any input into the general meetings or team meeting agendas and it was mentioned that often agendas are not circulated to the team in advance, but rather imbedded in the overview given at the start of the meeting.

The IAC had requested clarification on the process of creating "Fake caseloads 1 and 2" in the system. Cheryl Zaffino, Patient Service Manager (PSM) reviewed this and the IAC was able to ascertain how patients are prioritized. The PSM informed the IAC that a new process of introducing an asterisk (\*) at the beginning of a patient's documentation was being used to alert the CC's that an urgent need was present, as a mechanism to flag urgent priorities to be completed. The PSM reported that this was working well as a process. The inter-CCAC communicator system "LYNC" was also shown to the IAC. This also gave the IAC the opportunity to see the mechanism staff uses to primarily communicate with their colleagues at the CCAC.

The tour concluded at 1115 to prepare for the hearing commencement that afternoon.

#### **1.4.2 Hearing**

##### **1.4.2.1 Hearing Schedule**

The hearing was held over three days as follows:

June 17, 2014	1300-1745
June 18, 2014	0845-1110 1240-1635
June 19, 2014	0830-1030

The participants and observers who attended are listed in appendix G.

#### 1.4.2.2 Hearing Day 1

The IAC Chairperson commenced the hearing at 1300, by introducing the Independent Assessment Committee and undertaking a roundtable of participants from both the CCAC and the Association.

The IAC Chairperson reviewed the following:

- The jurisdictional scope of the IAC, including the purpose of the IAC and the agenda for the afternoon.
- The scope of the recommendations that were to be given by the IAC and the processes agreed to under the Collective Agreement section 24.
- The ground rules for the hearing procedure and confirmation that the participants understood.

Rozanna Haynes, Professional Practice Specialist presented on behalf of the Association. It was noted that this was the first IAC in the province that has occurred in any of the Ontario CCAC's. The ONA presentation was based on their written Pre-hearing submissions and supporting documents as well as a summary of the Professional Responsibility Complaints submitted between 2012 to May 20, 2014. It is important to emphasize that the IAC is subject to only the PRC's brought forward from January 2013, to May 20, 2014.

During their presentation, the Association stated the following themes that were consistent with the issues in the PRC's:

- Workload
- Staffing
- College of Nurses' of Ontario Accountability concerns related to documentation, Changes in the plan of care, Inability to assess/reassess in a timely manner, and ethical standards
- Standards of Case Management concerns
- Role clarity and scope of practice concerns with the Team Assistants, pharmacists and Therapists.

The Association's recommendations were in relation to the stated concerns presented.

The IAC and participants examined a webinar that was shown to all staff, on the Event Tracking Management System (ETMS) recorded in August of 2013, by the Quality Manager at the ESC-CCAC. This system allows for the tracking of active adverse events or incidents that involve patients or service providers. At this point in time, the ETMS is not tracking preventative measures or "near-misses."

Ms. Nancy Jammu-Taylor, legal Counsel for the CCAC, Tricia Khan, Kelley Doyle, Nadine Monroe-Wakenell, Lucy Coppola, and Cheryl Zaffino presented on behalf of the CCAC. The content of the CCAC's submission was based on their written pre-hearing and supporting documentation. Some of the highlights outside of the actual PRC's are listed below:

- The CCAC provided an overview of the service area and their patient needs specific to the region. An acknowledgement of the successes the ESC-CCAC has had in both the sector and the province was also provided.
- It was noted that the CCAC has a new Chief Executive Officer (CEO), Lori Marshall as of May 2014 and that a new strategic plan was to be launched in the coming months.
- It was presented that the year 2013, was a year of significant change for the CCAC with the adoption of the new Client Care Model (CCM). The CCM is a provincial framework, that each of the 14 CCAC's in Ontario have adopted, as it allows customization of care in each region. The CCAC provided an overview of the CCM and how it was piloted and then adopted at the Erie St. Clair CCAC. It was noted that some care areas were either increased or decreased for need of CC's, however there was no overall loss of positions as previously stated above.
- The CCAC also presented that a new Patient Service Management (PSM) position was created and one of the responsibilities within their portfolio was to assist with the PRC process. The CCAC acknowledged that there had been some confusion in regards to the process and the adherence to timelines from both parties.

The CCAC presented their issues of importance in relation to the PRC's presented as:

- Staffing Concerns
- Scope of Practice for the Care Coordinators
- Role Clarity
- The PRC process
- Program Changes
- ONA recommendations to address the above

The IAC Chair adjourned the hearing at 1745. Following adjournment of Day one of the hearing, the IAC met to review and synthesize the information provided for several hours that evening and to identify key concerns/issues to focus on for the hearing discussions on June 18, 2014.

#### **1.4.2.3 Hearing Day 2**

The IAC Chair resumed the hearing at 0845. The agenda and the ground rules were reviewed. Ms. Nancy Jammu-Taylor, Deb Johnson, Cheryl Zaffino, and Lucy Coppola provided the CCAC's response to the Associations submission. Members of the CCAC participated in the subsequent discussion. Following a lunch break, Ms. Rozanna Haynes supported by members of the Association, presented their response to the CCAC's hearing submission, including a presentation by 3 members from the Intake team. Following the presentations, members of both the CCAC and the Association participated in active discussion.

The IAC Chair adjourned the hearing, at 1635. Following adjournment of Day two of the hearing, the IAC met to review and synthesize the information provided, and to identify key concerns/issues requiring additional clarification and additional questions for the final day of the hearing.

#### **1.4.2.4 Hearing Day 3**

The IAC Chair opened the hearing at 0830. The IAC focused discussion through a series of questions relating to staffing, workload, role clarity regarding use of Team assistants, Therapists, and Pharmacists, and professional accountability. The Hearing participants actively participated in the discussion. The IAC felt that through the submissions from both parties, the active discussion and presentations that they had a thorough understanding of the issues presented.

Ms. Jammu-Taylor on behalf of the CCAC, and Ms. Rozanna Haynes on behalf of the Association provided final comments following the completion of the question and answer session. The IAC Chairperson's concluded the hearing at 1030 by thanking all participants for their engagement and commitment to the IAC process. The IAC Chair also communicated the hope that the recommendations made from the IAC would assist in the resolution of some of their issues. The Chair also confirmed that the final report would be provided within 30 days as per the Collective Agreement.

#### **1.4.3 Post Hearing**

##### **1.4.3.1 IAC Report Development**

The IAC met extensively over the course of the Hearing dates. Based on the information provided in the written submissions and in the hearing, recommendations were developed during the hearing process and afterwards. The IAC met after the hearing was adjourned on June 19, 2014 and further email correspondence, and two teleconferences were held to unanimously approve the recommendations and report. All IAC members contributed to the writing of the report.

##### **1.4.3.2 IAC Report Submission**

The IAC Report was submitted to the Association and the CCAC by email, in PDF format on July 10, 2014. A hard copy was also sent to both parties on July 10, 2014.



## **Section 2-Presentation of the Professional Responsibility Complaints**

### **2.1.1 Events prior to the referral of the Professional Responsibility Complaints and the Association's Perspective to those Issues.**

The Erie St. Clair (ESC) CCAC is an amalgamation of three geographical sites: Windsor-Essex, Chatham-Kent, and Sarnia-Lambton. It is one of 14 CCAC's in the province of Ontario. The CCAC's are responsible for "completing assessments and connecting the care needs of the patients in the community, at home, schools, hospitals, and a variety of settings within their respective regions<sup>3</sup>. A mandated role for the CCAC's is to minimize differences so that an individuals experience will be similar from one CCAC to another.<sup>4</sup> It has been noted that the volume of services required from the ESC CCAC has steadily increased annually over the past several years.

In 2012, resulting from dramatic increases in service needs and successful program implementation, a significant deficit was forecasted and a "Balancing the Cost of Care" strategy was initiated. The strategy focused on eliminating inefficient processes and creating effective models of care<sup>5</sup>. The result of this initiative was a positive cash position and what the CCAC believes is a stronger and improved organization.

In early January 2013, the Client Care Model (CCM), a model developed and supported by the Ontario Associations of Community Care Access Centres (OACCAC), was introduced at the ESC-CCAC. According to the Ontario Associations of Community Care Access Centres<sup>6</sup>, the new CCM was to:

- Provide a deeper, more focused understanding of client populations and their needs while supporting a positive care experience.
- Match case management/ care coordination intensity to client needs.
- Meet the needs of clients as they change and facilitate system navigation.
- Shift the focus to monitoring and achieving client outcomes.
- Encourage and support individuals to be engaged in managing their health care.

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<sup>3</sup> ESC-CCAC Submission Brief, pg. 3. The CCAC description.

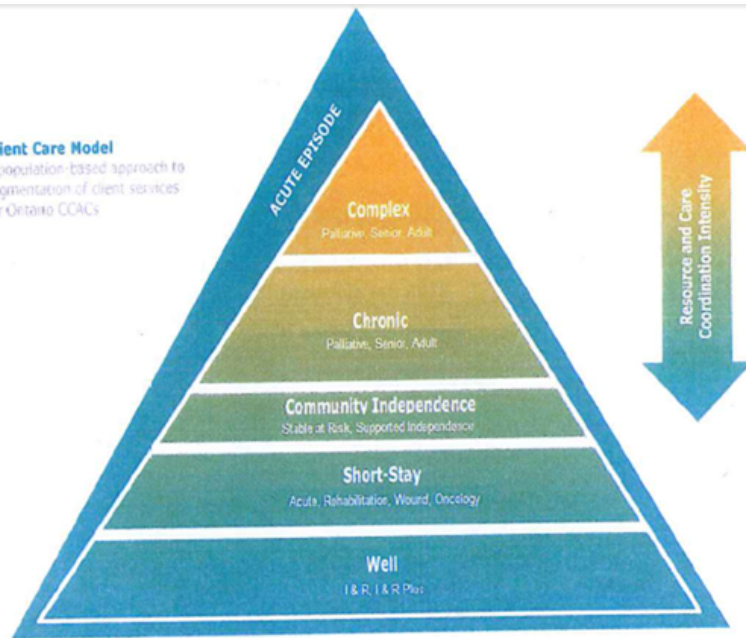
<sup>4</sup> ESC-CCAC Submission Brief, pg. 1. Background and history of CCAC.

<sup>5</sup> ESC-CCAC Submission Brief, pg. 7.

<sup>6</sup> OACCAC (2012). Client Care Model. Retrieved from <http://oha.mediasite.com/Mediasite/Play/36d22b3a1fa84f2bb8ac858db64289571d>

#### Client Care Model

A population-based approach to segmentation of client services for Ontario CCACs



The Client Care Model identifies five populations served by the CCAC: Complex, Chronic, Community Independence, Short Stay, and Well. Care Coordinators, who at the ESC-CCAC are 90% Registered Nurses and the other 10% of the CC's are Regulated Health Care professionals such as Physiotherapists, Occupational Therapists, Social Workers, and Speech-Language Therapists, are responsible for developing quality, timely, and cost-effective individual plans of service provision, based on patient needs utilizing a multi-disciplinary approach to achieve optimal health outcomes.<sup>7</sup> Care Coordinators must assess needs, determine eligibility based on eligibility criteria, and develop, authorize, monitor and evaluate plans of service. These plans of service may include professional services, personal support services, homemaking services, and school services as well as supplies, equipment or other goods within their legislated authority<sup>8</sup>.

Within each weighted caseload, the Ontario Association of Community Care Access Centres (OACCAC) recommends Caseload volumes within prescribed ranges. Below is a table that represents the caseload volumes at the ESC-CCAC against the recommended volumes from the OACCAC.<sup>9</sup>

<sup>7</sup> ESC-CCAC brief submission, pg. 13. General overview of the Care Coordinator.

<sup>8</sup> MOHLTC CCAC Client Services Policy, January, 2007 see [http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/cspm\\_sec\\_6/6-3.html](http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/cspm_sec_6/6-3.html)

<sup>9</sup> ESC-CCAC Submission Brief, Pg. 11.

<b>Client Population</b>	<b>ESC-CCAC Caseload Volume</b>	<b>Recommended Volume OACCAC</b>
<b>Adult-Chronic</b>	Adult-100	80-100
<b>Adult-Chronic</b>	Palliative-100	80-100
<b>Adult-Chronic</b>	Senior-100	80-100
<b>Adult Community Independence</b>	Stable-At risk-150	140-160
<b>Adult Community Independence</b>	Supported Independence-150	140-160
<b>Adult-Complex</b>	Adult-50	40-60
<b>Adult-Complex</b>	Palliative-50	40-60
<b>Adult-Complex</b>	Senior-50	40-60
<b>Adult-Short Stay</b>	Acute/Oncology/Rehab/Wound-250	200-300

The Resident Assessment Instrument (RAI-HC) is an assessment tool that is to be completed by the Community CC's. The RAI has been adopted as the comprehensive, standardized instrument for evaluating the needs, strengths and preferences of adult long-stay individuals in the community, including individuals requesting admission to LTC homes. The RAI-HC has been implemented in all CCACs.<sup>10</sup> In order to maintain a level of competency with these RAI's, the ESC-CCAC requires that 10 of these assessments be completed per month by those CC's who are trained to complete them, with the target goal of 16 per month.

It is important to note that not all CC's for example Float CC's, are trained to perform RAI assessments with patients. There are often backlogs in overdue RAI assessments and several PRC's have been filed on this issue. Assessments are required to be completed, along with reassessments in a timely and prescribed manner. CC's report that the RAI is only a small portion of their workload, yet they feel "pressured to make them a priority."

A Proof of Concept of the new CCM was completed in September 2012 and results were shared with both ONA and all of the staff within the ESC-CCAC, including a video that is

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<sup>10</sup> MOHLTC CCAC Client Services Policy, January, 2007 see [http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/cspm\\_sec\\_6/6-3.html](http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/cspm_sec_6/6-3.html)

posted on You Tube.<sup>11</sup> The Proof of Concept confirmed the CCM was a positive change for the CCAC and it permitted the Team Assistants (who provide clerical support to the CC's), to be "part of the client journey" and have "added value to the team."

Care Coordinator's hold specific positions within the areas of:

- Intake
- Hospital Intake/Outpatient and Overflow
- Short Stay
- Community
- Placement
- Care Connector
- Care Coordinator Floats

There are specific CC's assigned to these areas, but Float CC's are relied on excessively at the ESC-CCAC. The Float CC's are used to backfill vacancies, cover unexpected sick calls, and provide assistance to the teams as needed. These regulated health care professionals positions are part and/or full time and they are scheduled for shifts during the week, weekends and holidays. Since the introduction of the Client Care Model and the introduction of several new programs, it was noted by Management, that the Float pool across all three sites was depleting. Staffing was becoming a challenge and with the current Collective Agreement language in article 10, section 10.2 regarding temporary vacancies there could be no hiring of temporary staff unless the vacancy exceeded 60 calendar days<sup>12</sup>.

The table below represents the Care Coordinator staff numbers pre and post adoption of the Client Care Model<sup>13</sup>. It is important to note that there was a discrepancy between the Association and the ESC-CCAC's number of FTE's that had been added since the implementation of the CCM. The Human Resources at the ESC-CCAC provided the IAC with the following numbers of CC pre and post CCM adoption.

<b>Site</b>	<b>Pre CCM</b>	<b>Post CCM</b>
Chatham	46	50
Sarnia	48	50
Windsor	127	136

These particular staffing counts differ by 15 CC FTE's however, from the figure ONA had brought forward. In confirming the number of FTE's post-hearing with both ONA and the

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<sup>11</sup> Proof of Concept video on You tube, 2012 see  
<https://www.youtube.com/watch?v=9ugQ2cuaYWs>

<sup>12</sup> Collective Agreement between ESC-CCAC and ONA, expiry March 31, 2014.

<sup>13</sup> Email Correspondence, June 19, 2014 from Ms. Leonard HR Manager ESC-CCAC

ESC-CCAC, it was revealed by the ESC-CCAC that there was indeed the intention to add 15 positions with the introduction of the CCM, 8 of which have been filled. Currently, seven of these positions persist to remain vacant<sup>14</sup>, one and half years after the initial implementation of the model.

Caseloads began to increase in most areas and the Float CC's were being reassigned in their shifts to assist where there was an increased need. CC's began to express frustration at not being able to meet the requirements for visits, nor being able to meet the needs of their patient's. Below is a table that represents the FTE's pre and post adoption of the CCM, where it can be noted that no CC's positions were lost but rather reassigned, and in fact in some areas increased.<sup>15</sup> Again, it is important to mention the existence of the still 7 remaining vacant CC positions, when interpreting these numbers.

#### **FTEs – Pre and Post CCM WINDSOR**

AREA	PRE CCM	POST CCM
Districts/Community	34	32
School	4	4
Care Connector	1	1
BSO	1	1
Intake	12	16 (includes Overflow)
Short Stay	3	7
Education	1	1
Telemedicine	1	1
Placement	10	9
Oncology	9	8
Hospital	21	20
FT Floats	17	17
PT Floats	.5	2.5
Primary Care Liaison		1
Nephrology		1
Telehomecare		1
TOTAL	114.5	122.5

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<sup>14</sup> Email Correspondence, July 3, 2014 from Ms. Nancy Jammu-Taylor, Legal Counsel.

<sup>15</sup> Email Correspondence, June 14, 2014 from Ms. Nancy Jammu-Taylor, Legal Counsel.

### CHATHAM

AREA	PRE CCM	POST CCM
Districts/Community	15	11
School	2	2.5
Short Stay	1	3
Oncology	3	2
Intake	4	4 (includes Overflow)
PCS	2.6	3.6
Hospital	6	6
Educator	1	1
Telemedicine	1	1
FT Floats	4	6
PT Floats	3	1.5
Care Connector		1
Primary Care Liaison		1
TOTAL	42.6	43.6

### SARNIA

AREA	PRE CCM	POST CCM
Districts/Community	12.5	11
School	2.5	2.5
PCS	4	3
Intake	4	5
Care Connector	1	(moved to Chatham)
Short Stay	1	3
Oncology	3.6	4
Education	1	1
Hospital	7.5	8
FT Floats	6	7
PT Floats	.5	
Telemedicine		1
TOTAL	43.6	45.5

### **Staffing**

Care Coordinators expressed frustration at the inability to have consistent staffing in the areas of Intake and in the Community teams. Overtime was permitted inconsistently in some areas according to some ONA members and home visits were required to be cancelled, in order for the CC's to address priorities at their desks. CC's feel strongly that they are being scrutinized to perform more RAI's per month, to meet the goal of 16, but feel they cannot leave their desks unattended in order to do so, due to the lack of adequate coverage.

Community CC's are required to provide "Back up" to their teams approximately 5-6 times per month, to allow for desk relief. The Association strongly feels that they require more

CC's to assist in providing the necessary services at the ESC-CCAC or at least have consistent coverage in the teams.

ONA members felt that their work was being scrutinized through workload audits, which were performed by management, in follow up to workload PRC submissions. ONA states that those CC's were further questioned about discrepancies that were in staff calendars. The CC's state they are "Care Coordinators" not "RAI assessors". They feel strongly that the ability to care for their patients is deteriorating. Further to these audits, CC's state they do not regularly have performance appraisals by their PSM's, which made the audits appear punitive.

The ESC-CCAC countered that the audits revealed some productivity questions, which required management to speak to the CC's in order to clarify what had been completed. It was not intended to be punitive.

Care Connectors are also reporting a significant backlog in work as well. This position assesses needs and refers individuals without a regular healthcare provider to physicians and nurse practitioners. Unattached patients are registered into a provincial database in order to connect them with a service provider. These CC positions report being behind 2000-3000 calls due to staffing issues as well.

In an effort to allow CC's more time to complete their patient assessments and to streamline processes across all 3 sites, management gave increased responsibilities to the Team Assistants (TA), namely those TA's who worked in Information and Client Resource (ICR-TA) and the Case Management Services. Those enhanced functions will be discussed below.

ICR-TA's provide support to all individual calling into the ESC-CCAC and log these calls into a central queue, where all calls in the ESC-CCAC are equally distributed and answered<sup>16</sup>. The ICR-TA receives all calls related to information and referral, completes the patient registration for new admissions, and provides support to the service providers relating to service offers or redirects the caller to the appropriate staff member<sup>17</sup>. TA's are the clerical support to the CC's and have some enhanced functions. ONA's perspectives on the PRC concerns will be listed with the issues below:

### **The Expanded Role of the Team Assistant (TA).**

In an effort to alleviate workload from the CC's, management increased the responsibilities of the TA's in several areas such as authorization of equipment, touch point phone calls, authorization of visit dates for therapies, and infusion updates. These changes to the role of the TA have caused some angst with the CC's and several PRC's were filed to seek clarification on the expanded role to ensure TA's were functioning within their scope of

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<sup>16</sup> ESC-CCAC Brief submission, pg. 23, Team Assistants.

<sup>17</sup> ESC-CCAC Brief submission, pg. 23, Team Assistants.

practice. A source of frustration was the revising of the Client Reference Manual three times by management in the last month alone. It was recognized that the TA's role was evolving and the business processes were often required to change to accommodate this.

### **Equipment Authorization**

Under the new RFP for equipment, an approved catalogue of equipment is available for community therapists and CC's. The TA under this process is able to order equipment from the Community Therapist without the authorization of the CC. This initiative was developed in order to remove the delays in the ordering of equipment during extended hours and on weekends and to align all 3 sites of the ESC-CCAC. Prior to the amalgamation, the Windsor-Essex site performed this process as a standard practice<sup>18</sup>.

### **Touch Point Phone calls by TA's**

TA's also began making courtesy or "touch point" phone calls to patients if the Care Coordinator had not done so, within 72 hours of the initiation of service. The purpose of this call was to ensure the plan is in progress and the patient has the appropriate information to contact the Service Provider and their Care Coordinator.

The script asks questions such as:

1. If the patient/Caregiver has been contacted or visited by the Service Provider
2. If the patient has the provider contact information
3. If the current services were meeting their needs
4. If community linking had been established
5. If a home visit had been scheduled
6. If the client was provided with the CCAC contact information<sup>19</sup>.

The CC's feel by way of these particular phone calls, the TA's are assessing patient's eligibility for services, "triaging" referrals, "authorizing service provider visits" and "documenting" patient care.

### **See by dates**

Rework was caused in the ordering of therapy services when therapists would need to call in to the CC to request that the visit timeframe be adjusted for several reasons including: patient declining visits, needing to visit when equipment ordered, other conflicting appointments etc. A new process was implemented to remove the administrative burden of having to readjust visit dates in the CCAC system. CC's were directed to provide "see by dates" for therapies in relation to a block visit process. Therapies are directed through the Service Priority Rating Tool (SPRT) to see clients according to what the CC had assessed as their visit requirement (very high, high, medium, and low). In the new process, a CC would enter a "see by 30 day date" as directed by management to capture contractual agreements

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<sup>18</sup> ESC-CCAC Submission Brief, pg. 58.

<sup>19</sup> ESC-TA Scripting: CHRIS Note templates-Standards of Care.



with the Service Providers and also a SPRT priority, which indicates how quickly the therapist would need to visit the patient. The “see by 30 day” statement allows the service provider to continue to attempt to see the patient, if the patient has rescheduled or refused the visit, within that 30-day period without calling the CC for approval for another visit. Contractually, service providers are required to see their patients within the time frames of the SPRT. CC’s again feel that they are not being allowed to coordinate the care of their patients.

### **Infusion Order Updates**

Infusion Order Updates were also tasked to the TA’s to alleviate workload from the CC’s. Currently, a Pharmacy Vendor obtains corrections to incomplete orders and then faxes changes to the TA, to be entered into the patients chart and send notification to the service provider. The CC has been directed by management to initiate a service plan with a minimum service plan of 7 days, even if the orders are incomplete. This is completed in order to not delay the process of ordering the nursing services until a pharmacist clarifies the order.

Although, CC’s do not take verbal orders, they feel responsible for the incomplete order and the fact that they have ordered nursing visits to occur with said incomplete order.

### **Walk-in Referrals**

On occasion Patients will come directly to the CCAC to make a referral. Currently, if a patient or family member presents to reception at the ESC-CCAC, a TA takes their basic information and provides them with the CCAC Handbook, the Privacy Statement, a CC’s business card and told a CC will be in contact with them. The TA then initiates a pending referral and sends the referral to the CC to prioritize. The Patient is not assessed at this particular time. The CC’s feel that this is a lost opportunity to build rapport with the patient and begin an assessment.

#### **2.1.2 Intake**

An important role that the CC’s perform is the role of “Intake.” Intake CC’s act to triage patients for service to ensure the flow of referrals from urgent, high (next day or specific date), medium, or low. They triage calls from not only new patients seeking assessment and services but current patients as well (active patients) and document new patient information. In fact, 50% of the work of the Intake department is addressing calls and needs for the active patient population.<sup>20</sup>

From November 30-December 3, 2010, a Kaizen event was held to assist in improving the referral flow in the Intake department. The event recognized the need to “standardize integration of the ICR TA and Intake TA<sup>21</sup>” as one of the plans for the future. At this same event, it was recognized that “silos” in the delivery of care existed.

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<sup>20</sup> ESC-CCAC Brief submission, pg. 18, Intake back-up CC roles.

<sup>21</sup> ESC CCAC Dec, 2010 Intake Kaizen Event Report

Intake referrals come into the department either by fax, mail, walk-in, or telephone. The TA in Intake is to prioritize the referrals according to set guidelines<sup>22</sup> and placing them in the queue according to these priorities for the CC to assess. CC's feel that the TA's are "triaging" the referrals and again are acting outside of their scope in the role of an Unregulated Care Provider, because they are in essence "assessing patients."

ONA brought forward a document by the Ministry of Health and Long Term Care (MOHLTC) from 2007 titled "The CCAC Service Policy Manual<sup>23</sup>" and made reference to chapters 2 and 6 specifically, where it addresses the roles of the Case Manager, or Care Coordinator, as the name has now changed. It is important to note that in this document, timelines for reassessment are also noted on page 12 and 13 as well. Based on this document, the MOHLTC states the Care manager:

"must assess needs, determine eligibility based on eligibility criteria, and develop, authorize, monitor and evaluate plans of service. These plans of service may include professional services, personal support services, homemaking services, and school services as well as supplies, equipment or other goods within their legislated authority<sup>24</sup>".

The same document outlines, "The minimum qualification for persons that undertake these core functions in a CCAC is that the person be a registered health or social work professional. This includes, but is not limited to, a registered nurse, physiotherapist, occupational therapist, speech-language pathologist, social worker, dietitian and psychologist. These professionals are required to be members in good standing of their regulatory body."<sup>25</sup>

Due to the concerns being presented by the CC's, a working group in Intake was developed to address some of the concerns between the CC's and the TA's. This group was disbanded however, due to being non-functioning and having a "toxic environment". In fact, these

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<sup>22</sup> ESC CCAC Submission Brief, pg. 17.

<sup>23</sup> Ministry of Health and Long Term Care, 2007. Service Policy Manual chapters 2 and 6, see [http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/ccac\\_mn.html](http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/ccac_mn.html)

<sup>24</sup> Ministry of Health and Long Term Care, 2007. Service Policy Manual chapters 6, pg. 7, see [http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/ccac\\_mn.html](http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/ccac_mn.html)

<sup>25</sup> Ministry of Health and Long Term Care, 2007. Service Policy Manual chapters 6, pg. 16, see [http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/ccac\\_mn.html](http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/ccac_mn.html)

meetings were also subject to be part of some of the PRC's that were brought forward by the CC's. ONA reports that they were disappointed that the group disbanded, as there were opportunities for improvement that could have been sought from the group's expertise in Intake.

### **Documentation**

Care Coordinators also expressed concern that their Patient Service Manager (PSM) might "direct them" to change a patient's plan of care from their own assessment, but the PSM's would not document in the patient's record that they had made or suggested said change. The Association feels this is improper documentation by the PSM and as the CC documenting the changes; they are at risk of not complying with the documentation Standards of the College of Nurses'.

### **Event Tracking Management System (ETMS)**

The policy surrounding their Event Tracking Management System (ETMS) is also a subject of the PRC's. The current system does not track "near misses" of negative patient outcomes or adverse events. The CC's feel that this system is not preventative in nature but only addresses the active issues." Due to this fact, ONA members began using PRC's to track "near miss" concerns. ONA stated at the hearing that they had directed the CC's to fill out the PRC's forms to "protect themselves" as ethically they feel to not address, nor document potential issues, puts the CCAC at further risk. Risk management is an essential part of the care provided by the CCAC.

### **PRC Process**

The number of PRC's at the ESC-CCAC grew to a total of 66, from January 2013 to May 20, 2014. During this time, eight ONA/Management Labour Relations meetings were held to attempt to address the concerns. ONA expressed significant concerns with the lack of process that the ESC-CCAC was following due to not meeting set timelines as outlined in the Collective Agreement and very few of the PRC's filed had a manager's response documented. Further to this, ONA stated they were "advised by their PSM's to stop resubmitting multiple PRC's on the same issues." On February 25, 2014 ONA followed up with the ESC-CCAC in regards to this statement.

Due to the number of PRC's filed; the ESC-CCAC developed a new Patient Service Manager position under the umbrella of Professional Practice, to assist with the management of the PRC's. This position began in November 2013. Both ONA and the ESC-CCAC agreed that the process was not followed correctly and management stated there was definite incongruence with the process of what "having a discussion with management to address the PRC" entailed. ONA stated that management inserted an extra step into the PRC process by requiring the Member to meet with the Professional Practice PRC Patient Service Manager, as well.

ONA stated that management also rejected PRC forms and thus they felt that there was a lack of respect for their concerns for their work environment. The majority of the PRC's

presented in 2013, still present as on-going concerns. The Association feels that the process was “stalled,” and they were concerned that minutes of settlements of any PRC’s were not being tabled at any of the meetings.

Morale and communication at the ESC-CCAC is challenged. An Employee Engagement Survey was completed in 2013 and the feedback in the open-ended questions was not positive. Two hundred and twenty one responses were received, 187 were negative and 8 positive, and 25 had both positive and negative comments.<sup>26</sup> The comments identified 5 top areas for improvement recommended by the Staff:

- To be more involved with decision-making.
- To see an enhancement in communications.
- To see improvement in performance management.
- To have more manageable workload.
- To be consulted about changes that effect their team.

## **Summary**

The Association believes that there has been significant staffing and process challenges associated with the new Client Care Model. Key issues have been discussed above but the role and scope of the Team Assistant, staffing, the Professional Responsibility Complaint Process and the Event Tracking Management System of are particular concern for the members.

## **2.2 Erie St. Clair CCAC perspectives**

The perspectives of the ESC-CCAC on the issues presented above within the PRC’s related to the list below, will be discussed here:

- Staffing & Intake issues
- Ordering of Equipment by TA’s
- Scope of Practice concerns
- The entry of “see by dates” for therapy visits
- Infusion order concerns
- Walk-in Referrals
- Patient Service Manager Documentation
- Event Tracking Management System
- Professional Responsibility Complaint Process

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<sup>26</sup>ESC-CCAC, 2013. Employee Engagement Survey.

## **Staffing & Intake issues**

ESC-CCAC recognizes they use their float staff significantly and in fact see them as an integral part of the Intake department. Float CC's are required to assimilate a great deal of knowledge as they are used throughout the agency. An extensive 6-week orientation has been created and orientation checklists are required to be completed within 3 mos. Float CC's are required to achieve a level of comfort with assessments so that they can be versatile in their work.

The Intake team at the Windsor site is staffed 50% by Float CC's. The Intake department is staffed 7 days a week, 12 hours per day, including holidays. Currently, according to the Collective Agreement in article 17.05, not all full-time employees are scheduled to work weekends unless they agree; should the employer wish to introduce the scheduling of weekend work for FT staff, they must provide 6 months notice.<sup>27</sup> Floats were therefore introduced to assist in the coverage of the increased workload on weekends that had been noted by management. See table below for Weekend work statistics<sup>28</sup>.

Year	Month	WE 1 FK Tasks Completed
2013	Apr-13	81
2013	May-13	222
2013	Jun-13	352
2013	Jul-13	585
2013	Aug-13	571
2013	Sep-13	590
2013	Oct-13	635
2013	Nov-13	562
2013	Dec-13	503
2014	Jan-14	537
2014	Feb-14	490
2014	Mar-14	572
2014	Apr-14	643
2014	May-14	653

The ESC- CCAC is further challenged with their staffing due to significantly high absenteeism amongst the CC, especially in some teams. In one team particularly, they average 1.63 absent CC's per day. This only adds to the pressure on the usage of the Float staff or Back-up CC's required. A full time vacant position for weekends, also adds to the

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<sup>27</sup> Collective Agreement between ESC-CCAC and ONA, expiry March 31, 2014.

<sup>28</sup> ESC-CCAC, 2013-2014 Weekend Statistics, sent June 16, 2014 from Ms. Jammu-Taylor.

increased need for overtime for the CCAC. The Collective agreement language in article 10, section 10.2,<sup>29</sup> further limits the CCAC from hiring temporary staff into vacant positions as mentioned above.

Management presented that there were a total of 249 ONA members in 2013. In regard to absence rates for the year 2013, please see the below table for statistics<sup>30</sup>.

1503 Occurrences of Absence within ONA	An average of 6.03 occurrences/employee/year
2040.83 days of absences within ONA	An average of 8.19 absences days/employee/year or 8 additional employees working an entire year.
Chatham	Rate equivalents to 1.54 FTE's
Sarnia	Rate equivalents to 2.33 FTE's
Windsor	Rate equivalents to 6 FTE's

The CCAC recognized the issues with caseload sizes and attempted to address those issues by redistributing caseloads<sup>31</sup>. New reporting mechanisms were developed to assist with real time monitoring. Management states that 17 actions were undertaken to assist the CC's with the workload issues of a backlog of home visits, high volume of voice mail messages, etc.<sup>32</sup>. Many of the changes were welcomed by the CC's and did not result in any PRC's. Below highlights a few of the actions that the ESC-CCAC undertook, post adoption of the new CCM to assist the CC's<sup>33</sup>.

- TA's started booking all home visits for the CC's.
- CC's were required to commit to completing 4 assessments per week.
- Caseload distributions were changed.
- CC's were added to nephrology to assist with the oncology caseload as a back up.
- All vacant positions were filled. *(This is actually incorrect information that was presented in the submission, as there were actually 7 positions that remain vacant).*
- Home pronouncement plans.
- End of life initiatives.

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<sup>29</sup> Collective Agreement between ESC-CCAC and ONA, expiry March 31, 2014.

<sup>30</sup> ESC-CCAC Submission Brief, page 74.

<sup>31</sup> ESC-CCAC Submission Brief, pg. 42

<sup>32</sup> ESC-CCAC Submission Brief, pg. 50-52.

<sup>33</sup> ESC-CCAC Submission Brief, pg. 51

It was recognized that some factors are out of the control of the ESC-CCAC as they are mandated by the Government to complete initiatives within set timeframes. Furthermore, the opening of a new Long term Care Facility in the local area for July 2014 has also required additional resources for staffing.

It was also mentioned that some CC's are not completing the minimum number of RAI's per month to maintain competency or staff performance targets of 16 per month. Management has been noting that there are inconsistencies within workload of the CC's and that strategies for time management and workload balance need to also be discussed. It is recognized that there are many conflicting priorities within the organization and that flexibility is required.

Two Virtual Work trials were completed at the ESC-CCAC, May 28-Jun 1, 2012 and September 23-October 18, 2013. A letter of Understanding was completed with ONA in support of these trials as it is hoped that virtual work will become an important part of their future. The first trial concluded the High priority Intake calls and patient needs were met within a quick turnaround time overall but there were limitations outlined to this study. The second trial was completed over a longer period and was successful, but it was again noted that there were challenges such as obtaining accurate data to determine staff hours. There are plans to complete a third study in 2014, to assist in the workload of the Intake department across all 3 sites.

### **Ordering of Equipment by TA's**

As mentioned above, a new RFP process was implemented in May 2014 for equipment. Management deemed that the Service Provider, as a Regulated Health Care Professional should be able to order equipment from a CCAC approved catalogue and the Team Assistant would order the equipment requested by the therapist, eliminating the need for the CC to authorize as well. The Regulated Health Care Professional, namely the therapist ordering the equipment, is well suited and within their scope of practice to request this from an approved catalogue. They also state that any equipment that requires special authorization indeed needs to be processed through the CC

### **Scope of Practice concerns**

In an effort to assist with CC workload, Management began assigning some administrative tasks to the TA's. TA's are not seen as "unregulated healthcare providers" by management and they clarified this with the College of Nurses' of Ontario (CNO).

The PRC's surrounding the phone calls the TA's are making is a contentious subject. The questions being posed on the script and decision-tree were aligned provincially and there was feedback elicited from the CC's in regards to the questions. Management stated that if it was noted that a TA was asking questions outside of the script, than it was important for that to be reported, in order to properly address the issues with those individuals.

The reference to the TA's being "Unregulated Healthcare Providers" does not apply in managements' view. The TA's are following a decision tree and a script for the questions

and they are not assessing patients, nor are they performing any controlled acts. Although ONA had presented examples of times the TA's had asked "out of scope" questions, it could not be confirmed by ONA, if management had been notified by the CC's of these examples.

The ESC-CCAC noted that ONA's use of the words to describe some of the tasks the TA's were doing such as "triaging", "assessing" and "documenting" were incorrect and problematic.

### **The entry of "see by dates" for therapy visits**

Block visits are common practice in the CCAC and the Service Priority Rating Tool (SPRT) is used to assess patients for the urgency of the visit (See table below from the ESC-CCAC Business Process Manual)<sup>34</sup>.

**PT, OT Service Priority Rating Levels**

<b>Priority Level</b>	<b>Service Initiation</b>	<b>PT scenarios</b>	<b>OT scenarios</b>
<b>Very high=18-26</b>	<p><b>'Date Service Required by': 30 days</b> from CC assessment.</p> <p><b>Service Provider service initiation: within 72 hours</b> Some exceptions may apply with start date up to 5 days.</p>	<p>Patient requires urgent assessment and/or intervention related to an acute condition/situation:</p> <ul style="list-style-type: none"> <li>• Acute respiratory condition</li> <li>• Knee and hip arthroplasty</li> <li>• New amputees living alone or with poor caregiver support system, or who require teaching and/or assistance related to bandaging, transfers</li> <li>• Acute mobility issues related to fractures, acute neurological problems</li> </ul>	<p>Patient requires urgent occupational therapy to address safety, mobility and transfer issues:</p> <ul style="list-style-type: none"> <li>• Caregiver requires training</li> <li>• No reliable support and patient is new to the impairment</li> <li>• Major physical or cognitive impairment; sudden change in function</li> <li>• Immediate equipment needs related to mobility, transfers, skin integrity, positioning for essential tasks</li> </ul>
<b>High=13-17</b>	<b>'Date Service</b>	Patient has high physiotherapy care	Patient has high need for occupational therapy

<sup>34</sup> ESC-CCAC Business Process Manual, General Practice Section: Therapy Response Times.



	<p><b>Required by': 30 days</b> from CC assessment</p> <p><b>Service Provider service initiation: within: 5 days</b> from CC assessment</p>	<p>needs related to physical instability, treatment needs:</p> <ul style="list-style-type: none"> <li>• Acute pain of musculoskeletal origin affecting mobility and function</li> <li>• New amputees with good support system</li> <li>• Exacerbation of chronic chest condition</li> <li>• Surgically reduced fractures and compression fractures causing pain/reduced mobility, function and soft tissue injuries</li> </ul>	<p>related to physical and/or cognitive status requiring assessment and/or treatment:</p> <ul style="list-style-type: none"> <li>• General safety assessment for patient with known cognitive and/or physical impairment, and who has no support</li> <li>• Equipment and training needs for personal care</li> <li>• High risk of falls related to physical and/or cognitive impairment (based on assessment, history or caregiver report)</li> </ul>
<b>Moderate=9-12</b>	<p><b>'Date Service Required by': 30 days"</b> from CC assessment</p> <p><b>Service Provider service initiation: within 21 days</b> from CC assessment</p>	<p>Patients requiring physiotherapy treatment of a less urgent nature:</p> <ul style="list-style-type: none"> <li>• Short-term rehab follow-up for mobility issues related to musculoskeletal and neurological issues</li> <li>• Less urgent mobility and safety assessments</li> <li>• Chronic respiratory conditions</li> </ul>	<p>Patient need for occupational therapy assessment and treatment is less urgent.</p> <ul style="list-style-type: none"> <li>• Environmental/ADL assessment for patients discharged after lengthy hospitalization, where minimal risk exists</li> <li>• General bath assessments</li> <li>• General ADL assessments and training (safety and mobility not immediate concern)</li> <li>• Kitchen assessments, non-urgent safety assessment training (patient has reliable support)</li> <li>• Short-term rehab follow-up for transfer or ADL issue</li> </ul>

<b>Mild/low=4-8</b>	'Date Service Required by ' <b>: 30 days</b> of CC assessment  <b>Service Provider service initiation: within 30 days</b> from CC assessment	Patient requiring follow-up after long-term rehabilitation for mobility issues and equipment: <ul style="list-style-type: none"> <li>• Exercise routines</li> <li>• Chronic conditions with slow functional deterioration</li> <li>• Repeat referrals for any of the above</li> </ul>	Patient need for occupational therapy assessment and treatment is of a less urgent nature: <ul style="list-style-type: none"> <li>• Assessment for accessibility issues, energy conservation/work simplification, splinting</li> <li>• Follow-up after long-term rehab for ADL and equipment issues</li> </ul>
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The “see by 30 day” insertion into the patients chart is for contractual monitoring purposes and does not negate the rating of service provision from the SPRT according to Management. Data provided in both the submission from the CCAC and then at the hearing stated that patients are being contacted and seen well within their contractual obligations. Management supported the need for providers to update CC’s if the plan was changing.

### **Infusion order concerns**

The infusion orders are considered to be labour intensive, especially incomplete orders. The CCAC has a contracted pharmacy vendor and addressing these incomplete orders is well within their scope of practice. CC’s are notified when an order is changed by way of a fax, alerting them to changed orders along with the new order sheet. The priority is to ensure the nursing provider has the orders in order for the patient to not miss a dose. The CC has been directed to initiate a minimum 7-day frequency end date and should expect that the nursing provider will update them with any changes required to the visit schedule.

Due to the fact that CC’s do not take verbal medical orders, this should give the responsibility of the correction/clarification orders to the pharmacist. The incomplete order is within the scope of practice of both the service provider agency and the pharmacist. The incomplete referral however, is the responsibility of the CC to obtain missing information, such as the last dose given time.

Due to the PRC’s associated with this new initiative. Management in relation to this concern consulted the College of Nurses’ of Ontario (CNO) and the CNO felt that the process as it stands, currently meets standards. The nurses are “accountable for ensuring the accuracy, appropriateness, and completeness of a client’s plan in regards to the medication order and can meet this standard by: communicating orders with individuals

within the circle of care.”<sup>35</sup> The accountability then for the actual service provision lies with the service provider to inform the CCAC

### **Walk-in Referrals**

During the time frame of January to the present, Management reports 13 Walk-In referrals. The process for handling these types of referrals is further compounded, due to electronic means of how business is handled. When referrals come into the CCAC they are prioritized and put into a queue based on criteria. Management feels that when these types of referrals are given priority there is the opportunity then to move ahead in the queue despite prioritization criteria, which is then not equitable to the patients.

### **Patient Service Manager Documentation**

Management is willing to sign a letter of understanding with the union in regards to this particular issue. However, they state they do not arbitrarily make changes to the patients plan of care without discussion with the CC. There are ministry guidelines that outline what can routinely be provided to the patients and the managers have no issue with their names being in the patient documentation by the CC. Management states if they had direct contact with a patient, they would indeed document themselves in the chart, but this rarely occurs.

### **Event Tracking Management System (ETMS)**

The ETMS education was recorded in August 2013 and provided to all staff via a webinar. It was mentioned in this webinar that there currently was no mechanism to track near misses but that is would be coming in the near future. Management reports that there are a number of forms currently being filled out incorrectly, despite initial and review education to the CC's. There were reports that ETMS forms were being completed on events such as a “call being transferred to the wrong extension by a TA”. Management feels that the ETMS are being used as a means to forward further complaints about concerns that belong on a PRC form. It was recognized that “near miss” education is also required and the ESC-CCAC is committed to this.

### **Professional Responsibility Complaint Process**

The CCAC had a discussion with ONA about the process and agreed this was a definite area for improvement. Efficiencies in the process need to be addressed and the CCAC is currently looking to adopt an electronic process as of July 2014 that will alleviate some of these issues. Education to both management and staff is planned for this coming July, in hopes of increasing adherence to the process. The ESC-CCAC clarified that addressing the PRC's is only one part of the Professional Practice PRC Manager's portfolio. This manager is in fact responsible for several areas in the CCAC as well. The PRC PSM has a Master's degree with her thesis background in change management.

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<sup>35</sup> College of Nurses' of Ontario, Medication Administration Standards. See [http://www.cno.org/Global/docs/prac/41007\\_Medication.pdf](http://www.cno.org/Global/docs/prac/41007_Medication.pdf)

There was confusion surrounding what was to be considered a “fulsome discussion” surrounding the PRC’s that were filed. Management stated the “added step” referred to by ONA members, was their way of having a discussion rather than an email message or quick meeting about their concerns. They had not intended on this to be interpreted as another step, but merely as a way to communicate and clarify the concerns brought forward.

In regards to the concerns that management had refused to take anymore PRC’s, Management felt that the “submission of multiple PRC’s on a daily basis for the same issue, where discussions are taking place, does not lend itself to an efficient process”.<sup>36</sup> Management also states that the PRC’s were audited from January to the time the letter was sent, to ensure the process was being followed correctly. They also feel that they now have clarified the process and have a better understanding.

### **Summary**

It is to be noted that CCAC operates within budgetary confinements and they recognize that workload is of concern in some areas. The CCAC is committed to working with the Care Coordinators to address their workload concerns. They admit to errors on their behalf in relation to the PRC process and will work jointly with ONA to address these. They are also committed to giving Alliance and Information Referral (AIRS) Training to the TA’s in Intake as well as looking at the current caseload volumes and adjusting as necessary to assist with the workload of the CC’s. The ETMS system is undergoing changes as well, which should alleviate the concerns with the near miss risk management. It is important to note that the CCAC feels they have attempted to address some of the workload concerns of the CC’s by reassigning some of the administrative tasks but it is those tasks that have resulted in several PRC’s.

After several email discussions post-hearing, the IAC was able to ascertain that there are still 7 vacant CC positions yet to be filled post-CCM adoption.

## **Section 3-Discussion, Analysis & Recommendations**

### **3.1 Introduction**

The IAC believes that the panel has developed a comprehensive understanding of the professional responsibility concerns of the Care Coordinators at the ESC-CCAC. This understanding was developed through the reading of the submissions, details outlined in the hearing both oral and written, literature support, and the IAC’s collective experience with similar concerns. A discussion, analysis and the IAC’s recommendations will be listed under the subheadings in the next section.

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<sup>36</sup> ESC-CCAC Feb 28, 2014 Minutes from the Joint Association Meeting.

## 3.2 Discussion, Analysis, & Recommendations

### Staffing & Workload

Workload and staffing are significant issues at the CCAC. Effective staffing ensures that patient needs are being met and the work environment is palatable. The IAC noted that the use of Float CC is extensive and there is a consistent use of Overtime to address the backlog of work from absenteeism and inability to staff on weekends. It was presented in the submission from the CCAC that in 2013, there were 1503 occurrences of absence within ONA members and 2040.83 days of absence within ONA. This rate of absenteeism accumulates into 9.87 Full time equivalents (FTE).

Due to the high rates of absenteeism, an employee Absenteeism Support Program was implemented within the last few years, which should assist in the tracking and trending of this concern. It is clearly evident that an interim solution is required because what is currently being implemented is not successful.

Weekend staffing is problematic by a combination of the collective agreement barriers on management, vacant positions on weekends, and absenteeism. There is indeed some accountability on the Human Resource department to assist with active recruiting of staff and if workload is a concern, audits need to be consistently administered to ensure accountability of all CC's.

After much discussion post-Hearing it was discovered that there were to have been an additional 15 CC positions to assist with staffing of the new Client Care Model. Only 8 of these positions have currently been filled, leaving 7 vacant positions one and half year's post-implementation. These positions would greatly assist with the staffing needs of the ESC-CCAC, given the needs currently required.

The Association recommended the ESC-CCAC implement the Registered Nurses' of Ontario (RNAO) Best Practice Guideline (BPG) of Developing and Sustaining effective Staffing and Workload. While the IAC views this is an excellent tool with valuable suggestions, it is important to remember that not all Care Coordinators are nurses' and are therefore may or may not be subject to the same standards. This is not to say that some of the recommendations in the BPG would not prove useful to the ESC-CCAC's current practices and overall functioning of the organization.

### Recommendations

- 1. Recommend a consideration of a centralized Intake department across all 4 sites or utilize a centralized intake queue that can be accessed by all 3 sites to assist in the inequities in Intake volumes. The Virtual Work projects confirmed that this would be a feasible solution. If one were to follow L.E.A.N methodology, it would ensure standardization of work processes across all three sites. This would also ensure you had trained CC's able to complete the work.**

- 2. If the above is not an option, consider having receptionists to divert calls from the Intake department given 50% of the calls received in the Intake department are from active clients. This is considerable workload for this department that could be diverted to the community teams, who are familiar with the patients.**
- 3. The ESC-CCAC needs to be transparent about where the FTE's were added post CCM. If there is not an accurate system or mechanism currently in place to perform this task, the IAC recommends seeking a system that will perform this function. We recommend a dialogue about this at your next ONA/Labour Relations meeting.**
- 4. There are 7 vacant FTE CC positions yet to be filled from the numbers provided by the ESC-CCAC. These positions would greatly assist in decreasing overtime costs, which are extremely high. The current overtime hours for this year would have paid for 4 FTE's salaries out of the 7, which remain vacant. The IAC recommends the active recruitment of these Care Coordinator positions begin immediately.**
- 5. Dedicated Float Staff to teams consistently requiring the need could be used to assist in regular trained staffing assistance. Given Float CC are moved about the agency, having dedicated staff will allow them to develop a level of competence in a more meaningful manner and provide more consistent coverage to the teams.**
- 6. If the above option is not feasible, consider moving Float positions to permanent full-time on those teams requiring the added assistance (for example, Oncology, Care Connector's). This will provide consistent coverage for these teams, which will reduce the need for community care coordinators to provide back up coverage and allow them to increase the time making home visits.**
- 7. Recommend dialogue with the union to discuss if the increased workload on the weekends demands an increase of the number of staff included on the regular weekend tours. Consider a rotation for all full-time CC's to do a rotation of weekends due to the amount of work that seems to be occurring at this time.<sup>37</sup>**
- 8. We suggest the addition of some casual CC's to assist in times of increased need. This will assist in providing staffing coverage in these departments for vacancies, extended sick leaves etc. This will minimize the need to utilize float CC in the intake and hospital areas which will allow floats to be dedicated to the community areas.**

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<sup>37</sup> ESC-CCAC Submission Brief, pg. 31-32.

**9. Develop a workload measurement tool that will allow for improved tracking of work and staffing needs. The RNAO (2005) reports that is “essential that the work that nurses perform is understood. This requires the development of a means for identifying the specific contribution of nurses to patient outcomes as well as the resources required to affect this outcome”.<sup>38</sup> This will also allow management to support staff in relation to the provincial and local requirement set for individual performance (example # of RAI HC competency target and monthly performance target). The Engagement Survey completed in 2013, also supports this, as “staff would like to see that excellence in performance is recognized and those who require assistance are managed for improvement”.<sup>39</sup>**

**10. Utilize active recruitment strategies to hire both casual, part time and full time staff when needed.**

### **Scope of the Team Assistant**

The MOHLTC CCAC Client Service Manual (2007) states:

“Staff who do not have professional qualifications to carry out core case management functions may support the case management process by performing administrative tasks; however, these staff will still require decision-making skills and a sound understanding of the case manager role. Examples of activities that may be undertaken by other staff include, but are not limited to:

- directing calls received to the appropriate case manager or contracted service provider;
- obtaining basic information on intake to assist case managers to determine eligibility and facilitate access to program and community resources;
- ordering prescribed services, equipment and supplies approved by the case manager;
- scheduling services;
- cancelling drug benefit authorizations;
- notifying contracted service providers of changes to plans of service;

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<sup>38</sup> RNAO (2005). Nursing Workload Measurement System a discussion of the issues. Retrieved from <http://rnao.ca/policy/reports/Nursing-Workload-Measurment-Systems-Discussion-Paper>

<sup>39</sup> ESC-CCAC Employee Engagement Survey Results, 2013.

- handling communications of a non-urgent, non-case management nature;
- documenting receipt of reports;
- flagging reports requiring review by the case manager;
- assisting to maintain the client's record;
- undertaking follow-up calls to identified persons at the request of the case manager; and
- researching community options on request.

The above are examples of tasks that the CCAC may reasonably delegate to other staff and should not be considered responsibilities that must be undertaken by staff with professional qualifications. The delegation of these tasks will enable case managers to concentrate on activities that require their professional expertise".<sup>40</sup>

The IAC feels that TA's do not fit the definition of "unregulated Healthcare Providers (UCP), as defined by the College of Nurses' of Ontario (CNO), " The CNO states that an UCP refers to "a paid UCP, family member, or member of the household."<sup>41</sup> From the list above provided by the MOHLTC, the functions the TA are currently doing do not fall into this realm. Therefore, there would not be any need for a TA to be supervised by a nurse per say.

The IAC does however have concerns with questions #3 and #4 on the script that seem to delve more into a medical assessment and do warrant a CC to address. The CC can address those two specific questions on their initial phone call with the patient.

In regards to the information presented by ONA that some TA's were asking questions that could be construed as performing a medical assessment and definitely outside of their scope of work that is unacceptable. It is imperative that this type of information needs to be consistently reported to the manager, so they might address it and provide further education or discipline to that employee.

It is important to note that the language being used in the CCAC is promoting the culture where boundaries of work are being divided. The words "triage" when the TA's are

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<sup>40</sup> Ministry of Health and Long Term Care, 2007. Service Policy Manual chapters 6, pg. 17, see [http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/ccac\\_mn.html](http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/ccac_mn.html)

<sup>41</sup> College of Nurses' of Ontario, 2013. Working with Unregulated Healthcare Providers. See [http://www.cno.org/Global/docs/prac/41014\\_workingucp.pdf](http://www.cno.org/Global/docs/prac/41014_workingucp.pdf)



prioritizing referral according to set guidelines; “documenting” when the TA’s are reporting information in the patient chart; and “assessing” when the TA’s are asking questions outlined in the scripts are problematic and should be discouraged.

## **Recommendations**

- 11. Remove questions #3 and 4 from the TA script and allow the CC to ask those questions directly to ascertain medical information and delve further.**
- 12. Management should commit to certifying ICR-TA’s on AIRS training.**
- 13. Discourage the use of some of the language being used to describe the tasks TA’s are completing for administration. For example, some CC’s are referring that TA’s are “documenting” when they are reporting, “authorizing” equipment with they are ordering what is requested from a Therapist, etc. This will promote the use of common language that accurately describes what is being done, so as not to mistake it with the role of the CC.**
- 14. Ensuring any performance issues of questions being asked outside of the TA scope are reported to management for their attention and intervention. This was also supported in an All-Site Team Meeting on May 1, 2013 when the Standard of Care on soft transfer calls was discussed.** <sup>42</sup>

## **Equipment/See by Dates for Therapy/Infusion Orders**

The new RFP contract for **equipment** began in May 2014. There is now a prescribed catalogue of equipment that can be ordered for patients. Management has suggested that the TA can order the equipment that has been requested by a Regulated Health Professional, usually a Physiotherapist or an Occupational Therapist, as long as it is from the catalogue of management authorized items. They also agreed that CC would be notified that this task has been completed.

## **Recommendation**

- 15. Although the IAC appreciates that this is a time saving approach, the IAC is not in a position to suggest a recommendation given the MOHLTC-Client Services Manual 2007- states that is the role of the CM to authorize the equipment. The IAC believes the therapist who has assessed the patient is ultimately professionally responsible for ordering the equipment. This decision is clearly beyond the scope of this IAC and further clarification at a ministry level is required. As per the MOHLTC-Client Services manual (2006), “staff should consult senior management and management may contact the**

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<sup>42</sup> ONA Submission, Volume 2, section 45. All Site Team Meeting minutes, section 3.1.

**MOHLTC for further consultation or direction”<sup>43</sup>. We therefore would recommend management contact the MOHLTC for direction on this matter.**

The **See-by 30 days** visit schedule is also problematic for the CC’s. They feel by inserting this into the patient’s schedule it negates the priority given to them to see the patient by the SPRT. Although done strictly for contractual tracking purposes, the CC’s find it contradictory to the ordering of the SPRT. The audits completed on the therapist visits confirm that visits are being done timely and without concern and that the initial calls are happening within a timely fashion as well. The “see by 30 days” does to allow the Therapist to have the flexibility to see the patient outside of the timeframe of a SPRT recommendation if they have contacted the patient and are unable to visit for reasons such as: equipment has not been delivered, the patient is too tired, etc.

**16. The committee recommends a discussion occur to see if this “see by 30 days” statement is an absolute necessity and if it is not, then we recommend its removal and only using the SPRT when the CC orders therapies.**

Block visits for **infusions** are common practice with the CCAC’s. The CC’s have been directed to enter in a 7 day minimum visit block to cover infusions, as management feels the onus is on the service provider as part of their professional responsibility, to visit the patient as required and then update the CC on the visit frequency. Further to this, the supplies required are formulary and again do not require the CC to authorize.

Given the CC’s do not take verbal orders and there is a pharmacist who is contracted by the ESC-CCAC, it is recognized by both the IAC and ONA, that the Pharmacist is the best person to address infusion orders. Currently the CC is alerted by fax, with the words “changed orders” clearly displayed in regards to any changes in orders. This alerts the CC that the visit schedule might require adjustment.

## **Recommendation**

**17. TA’s should send a manual task to alert CC that a change in an infusion order has taken place. This will ensure that the visits are correct in the system.**

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<sup>43</sup> Ministry of Health and Long Term Care, 2006. Service Policy Manual see [http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/ccac\\_mn.html](http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/ccac_mn.html).

## Walk-in Referrals

The statistics provided do not support that this is a significant issue at the ESC-CCAC. Given the TA is providing the patient with a CCAC handbook, privacy statement and a business card of a CC who will follow up, this is a standard process for how a referral is addressed. The IAC sees this as an opportunity for someone to indeed “jump the queue” strictly based on the fact that they physically presented to the CCAC. This creates an unequal level of access that the prioritization provides. The TA is addressing a “Walk-in” referral the same as all referrals, which in the IAC’s opinion is currently creating an equitable process. It is important to note that the CCAC does not deliver emergency care, but rather based on need for service.

The IAC supports the current practice being completed by the ESC-CCAC in regards to this process.

## Documentation by a Patient Service Manager in a Chart

The IAC feels that when CC’s develop plans that require input from their manager, this is a joint effort and that the plan that is documented is based on the dialogue between the two staff members. The IAC feels that if a PSM had direct contact with a patient, indeed they should individually chart that interaction in the notes. The CCAC mentioned that they would sign a letter of understanding with ONA in regards to this but the IAC is not clear on the purpose of such letter.

## Recommendation

**18. The IAC recommends the Professional Practice Patient Service Manager contact the College of Nurses’ of Ontario to investigate if this is indeed a breach of the documentation Standard and if the letter of understanding is required.**

## Event Management Tracking System

Providing quality care in any healthcare setting is a fundamental goal. The current Event Tracking Management System allows for the documentation of incidents or adverse events that have occurred, but is lacking in the ability to track near misses. These near misses have great learning opportunity for an organization, but they need to be documented in order for the agency to use what they learned. When the ETMS was adopted last August, it was said that there would be the ability to track near misses in the future. Now almost one year later, this still remains an inability. The primary purpose of patient safety reporting is to learn from the experience and disseminate recommendations for a systems change<sup>44</sup>.

It was reported the service providers are eager to receive information on this as they feel

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<sup>44</sup> World Health Organization (2005). WHO guidelines for adverse event reporting systems and learning systems. Retrieved from [http://www.who.int/patientsafety/events/05/Reporting\\_Guidelines.pdf](http://www.who.int/patientsafety/events/05/Reporting_Guidelines.pdf)

when they report issues now, it “goes into a black hole.” The sharing of this information will be helpful to both parties and assist in mitigating adverse events. “Case managers must ensure that their practices use quality improvement, risk management and best practice principles that strengthen service delivery.”<sup>45</sup>

The CCAC stated they have yet to identify any serious occurrences and they have had good indicators of care to support this. However, to be conscientious with risk management is a responsible and accountable action to take.

## **Recommendations**

**19. Develop a means to track Near misses for adverse events. This will alleviate the CC’s from filling out PRC’s inadvertently to cover their professional responsibilities on an incorrect form. Management does report that the ability to do this in the current system will be available in the next 3 months.**

**20. Standardize a policy and a procedure for the ESC-CCSC on how near misses and adverse events will be shared with your service providers.**

## **Professional Responsibility Complaint Process**

The PRC’s are an important part of the Collective Agreement between ONA and the ESC-CCAC. Both parties mutually agreed that there had been some confusion surrounding this process. Communication has been an issue on both sides. There needs to be an awareness to adhere to process and timelines. Given these forms are now going to be electronic as of July 2014, there will be a need for education for both staff and management. The current Patient Service Manager with PRC’s under her portfolio is working closely with ONA to ensure proper procedure is followed.

It was mentioned by ONA that there was a Clinical Nurse Educator at the local hospital whom had developed what ONA deemed “an excellent Process,” for managing electronic PRC’s. The CCAC has already reached out to this person as a resource.

## **Recommendations**

**21. Provide the necessary education on the new electronic process in July 2014, to both management and staff.**

**22. ONA should continue to complete PRC’s as they apply and provide these to their managers. Management recognizes that is a requirement for the CC’s**

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<sup>45</sup> Ministry of Health and Long Term Care, 2007. Service Policy Manual chapters 6, see [http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/ccac\\_mn.html](http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/ccac_mn.html)

professional responsibility.

**23. The Process needs to be adhered to for the dialogue between with the PSM. This will ensure the manager has an understanding of the concern being presented and that the timelines can be followed.**

**24. The ONA/Labour Management meetings need to occur on a regular basis and minutes should be taken with detail at each meeting. A discussion surrounding an outstanding PRC's should be a priority. The IAC further recommends that PRC's should be a standing item on the ONA/Labour management meeting agendas.**

## **Morale**

It was quite evident to the IAC Panel that the staff at the ESC-CCAC is passionate about their work and dedicated to the care of their patients. Although an amalgamation of 3 sites, there does not seem to be a culture of one collective site. The Engagement Survey completed in 2013, speaks to the tension that is palpable at the ESC-CCAC. There were reports of unprofessional behaviours and a “toxic” work environment from some CC's.

Staff members of the ESC-CCAC need to demonstrate the values of their organization of efficiency, compassion, dignity, accountability and communication. There appeared to be a level of intolerance at all levels due to the current culture at the workplace. The IAC would make the assumption that perhaps the levels of absenteeism could also be correlated to the current work environment. A healthy work environment will promote the health and well being of all those who work there.

The current division of professions in the ESC-CCAC is also problematic. It was suggested that the CC's complete an in-service to other staff to explore their role, scope and function. The IAC strongly feels that Inter-professional collaboration is essential in this setting and that not only should the CC's highlight their role but the TA's, Therapists, etc. as well. The World Health Organization defines *collaborative practice* in health care as occurring “when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, caregivers and communities to deliver the highest quality of care across settings<sup>46</sup>.” By sharing their role and scope of practices, not only will client services be improved but patient access as well.

Another issue is the feeling that staff is not involved in new initiatives from the beginning. The IAC recognizes that provincial initiatives come quickly and do not always allot time for staff input. When possible, working groups should be struck to ensure staff is able to participate in the business processes that are initiated. This will assist with improved communication and dissemination of information within the organization.

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<sup>46</sup> World Health Organization, 2010. Framework for action: Interprofessional Collaboration and Education. Retrieved from [http://whqlibdoc.who.int/hq/2010/WHO\\_HRH\\_HP\\_N\\_10.3\\_eng.pdf?ua=1](http://whqlibdoc.who.int/hq/2010/WHO_HRH_HP_N_10.3_eng.pdf?ua=1)

The wall between the CC's and the TA's seems to be adding to the feeling of "silos." Although there was some noise reduction with the half wall partition, it only adds to the barrier that the CC's feel there are now between the two professions.

The CC's and TA's do not consistently meet as a team in all areas. This again adds to the feeling of being separate entities, especially as the managers are not the same person either. There is also the issue of agenda's not being circulated for staff prior to staff meetings, which gives them little input into the meetings or the ability to prepare for a fruitful discussion. Team building is essential in areas where collaborative practice is required.

Staff also reported not having regular performance appraisals to track their work performance. Several staff reported having a "balanced scorecard review" but not a performance review. Staff seemed keen to want to know about their progress in their role as a CC and not be told strictly about how they were performing on their RAI targets.

## **Recommendations**

- 25. Team building is going to be essential in the current work environment. The ESC-CCAC currently has a Patient Service Manager with a background in empowerment and change management that should be able to engage the staff to improve communication, conflict resolution and active staff participation. Mutual goal setting between managers and CC's should be encouraged through regular team building sessions.**
- 26. Provide inter-professional education sessions on all staff at the CCAC, to promote an understanding of the important role each play as part of a multi-disciplinary team.**
- 27. The IAC recommends Erie St Clair CCAC continue to host additional LEAN events (demonstrating a commitment to continuous quality improvement which will Kaizen, Value Stream Analysis, etc.) continue to build efficient workflow processes, standardize work, increase capacity and promote frontline staff engagement.**
- 28. The IAC would recommend that a discussion occur between the TA's, CC's and management to ascertain if the wall is indeed desirable and/or necessary. Although it may be slightly effective in noise reduction, it may be presenting an obstacle towards the team functioning as a cohesive group.**
- 29. All Team meetings and staff meetings should have an agenda circulated 1-2 weeks in advance of the meeting. A call for agenda items should also be added to ensure staff input is being encouraged. Frequent staff meetings and/or Team meetings will assist with improved communication amongst all team members and enhance overall morale.**

**30. Efforts should be made to have a consistent and timely performance review with all staff on an annual basis and consistent 1:1 meetings with staff between performance appraisals to set goals, monitor progress and review scorecards regularly.**

**31. The IAC would encourage the use of the recommendations in the RNAO Best Practice Guideline on Healthy Work environment, workplace health, Safety and Well-being of the Nurse <sup>47</sup> where applicable, to assist with conflict resolution, organizational culture, and improved communication. Again, recognizing that not all Care Coordinators are not nurses' and are therefore may or may not be subject to the same standards, these recommendations in the BPG may still prove useful to the ESC-CCAC's current practices and overall functioning of the organization.**

**32. The IAC acknowledges the suggestion by the Association to have an ethicist review new policies and procedures and agree there may be merit to having that level of input and also in having ethical training for all staff. The IAC would recommend a discussion regarding the usefulness of an ethicist.**

#### **Section 4-Conclusion**

##### **4.1 Conclusion**

The process undertaken by the Independent Assessment Committee allows for dialogue to occur between two parties who come to an impasse. The Committee has made a total of 32 recommendations to assist with the PRC's as brought forward from the Care Coordinators at the ESC-CCAC. The IAC members unanimously support these recommendations and are hopeful that they assist both the ESC-CCAC and the Association to find mutually agreeable terms to address the PRC's.

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<sup>47</sup> RNAO (2008). Best Practice Guideline: Healthy Work environment, workplace health, Safety and Well-being of the Nurse. Retrieved from [http://rnao.ca/sites/rnao-ca/files/storage/related/3090\\_RNAO\\_BPG\\_Health\\_Safety\\_summary.pdf](http://rnao.ca/sites/rnao-ca/files/storage/related/3090_RNAO_BPG_Health_Safety_summary.pdf)

## Appendix A



### Ontario Nurses' Association

85 Grenville Street, Suite 400, Toronto, Ontario M5S 3A2

TEL: (416) 964-8833 • FAX: (416) 964-8864

August 13, 2013

Tricia Khan  
Director  
Erie St. Clair Community Care Access Centre  
712 Richmond Street, Box 306  
Chatham, ON N7M 5K4

Dear Ms. Khan,

**Re: Professional Responsibility**

Pursuant to Article 24 of the collective agreement, please be advised that the Union has brought forth the issue of Professional Responsibility. The care coordinators of Erie St. Clair CCAC have identified ongoing workplace and practice concerns as evidenced by the data submitted on Professional Responsibility Workload Report Forms. Please find attached a recent copy of a Professional Responsibility Workload Report Form.

The purpose of this letter is to advise that at this time the local executive has requested the assistance of Professional Practice to assist with the unsatisfactory resolution of workload concerns to date. We are hereby informing you that the Labour Relations Officer and the Professional Practice Specialists will be attending a meeting of the Union-Management Committee scheduled to proceed on September 19, 2013, to discuss and attempt to resolve all unresolved Professional Responsibility Workload Report Forms completed prior to September 13, 2013.

After this meeting, should these workload issues remain unresolved, these issues will be referred to ONA's Professional Practice Specialist(s) and thereafter the parties can agree to extend the timeline in the Collective Agreement or the Specialist(s) may proceed to a formalized Professional Responsibility Complaint and/or Independent Assessment Committee hearing.

Yours truly,

**ONTARIO NURSES' ASSOCIATION**

  
for Rozanna Haynes  
Professional Practice Specialist

C: Catherine Iles-Peck, Labour Relations Officer  
Sue Gelinas, Bargaining Unit President  
Janice McFadden, Local Coordinator  
Betty Kuchta, Chief Executive Officer of Erie St. Clair CCAC

Provincial Office: Toronto

Regional Offices: Ottawa • Hamilton • Kingston • London

Orillia • Sudbury • Thunder Bay • Timmins • Windsor





## Appendix B



### Ontario Nurses' Association

85 Grenville Street, Suite 400, Toronto, Ontario M5S 3A2  
TEL: (416) 964-8833 • FAX: (416) 964-8864

November 20, 2013.

Ms. Laralea Stalkie  
1146 Harmony Road  
Corbyville, ON K0K 1V0

*By regular mail*

Dear Ms. Stalkie:


**Re: Erie St. Clair Community Care Access Centre: Professional Responsibility  
Complaint – Independent Assessment Committee – ONA File # 201302931**

Thank you for accepting our request to chair an Independent Assessment Committee (IAC) tasked with assessing the merits of a complaint regarding the Erie St. Clair Community Care Access Centre (Erie St. Clair CCAC). The Ontario Nurses' Association (ONA) has consulted with Ms. Kelley Doyle, Senior Director at Erie St. Clair CCAC and both parties have agreed to you chairing this IAC.

The attached letter provides the name of ONA's nominee as well as her contact information. Once the Erie St. Clair CCAC has identified its nominee, we ask that it provides you with his or her name and contact information. When you are provided with this information, please confirm dates for the IAC with the nominees, who will then confirm with their respective parties.

Yours truly,

**ONTARIO NURSES' ASSOCIATION**

*for* 

Vanessa Yanagawa  
Professional Practice Specialist

Phone: 416-964-8833 ext. 2297

1-800-387-5580

Fax: 416-964-8864

E-mail: [vanessay@ona.org](mailto:vanessay@ona.org)

/vg/al

C: Sheila Gringas, ONA Nominee, *by regular mail*  
Kelley Doyle, Senior Director of Erie St. Clair CCAC, *by regular mail*  
Betty Kuchta, Chief Executive Officer of Erie St. Clair CCAC, *by regular mail*  
Sue Gelinis, Bargaining Unit President, *by regular mail*  
Janice McFadden, Local Coordinator, *by email*  
Catherine Iles-Peck, Labour Relations Officer, *by email*

Encl.

Provincial Office: **Toronto**

Regional Offices: **Ottawa • Hamilton • Kingston • London**

**Orillia • Sudbury • Thunder Bay • Timmins • Windsor**



## Appendix C



### Ontario Nurses' Association

85 Grenville Street, Suite 400, Toronto, Ontario M5S 3A2

TEL: (416) 964-8833 • FAX: (416) 964-8864

November 20, 2013

Ms. Sheila Gringras  
318 Prince Edward Rd. 28  
RR#7  
Belleville, ON K8N 4Z7

Dear Ms. Gringras:

**Re: Erie St. Clair Community Care Access Centre: Professional Responsibility  
Complaint – Independent Assessment Committee – ONA File # 201302931**

Thank you for accepting our nomination to sit on the Independent Assessment Committee (IAC) which is tasked with assessing the merits of a complaint regarding the Erie St. Clair Community Care Access Centre (Erie St. Clair CCAC). The Ontario Nurses' Association (ONA) and the Erie St. Clair CCAC have mutually agreed that the chair of this IAC will be Laralea Stalkie. While the name of the nominee for the Erie St. Clair CCAC remains outstanding, we expect to receive this information shortly and thereafter you will be contacted by Ms. Stalkie to confirm a date for the IAC hearing to proceed.

In the interim, should you have any questions or concerns, please feel free to contact the undersigned.

Thank you.

Yours truly,  
**ONTARIO NURSES' ASSOCIATION**

Vanessa Yanagawa  
Professional Practice Specialist

Phone: 416-964-8833 ext. 2297

1-800-387-5580

Fax: 416-964-8864

E-mail: [vanessay@ona.org](mailto:vanessay@ona.org)

/vg/al

C: Ms. Laralea Stalkie, Chair, *by regular mail*

Provincial Office: Toronto

Regional Offices: Ottawa • Hamilton • Kingston • London

Orillia • Sudbury • Thunder Bay • Timmins • Windsor



## Appendix D

Betty Kuchta  
Chief Executive Officer of Erie St. Clair CCAC  
Erie St. Clair Community Care Access Centre  
712 Richmond Street, Box 306  
Chatham, ON N7M 5K4

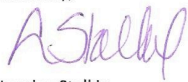
Dear Ms. Kuchta

Jan 21, 2014

As you know, I have been selected to chair the Independent Assessment Committee charged with conducting a hearing into the complaint currently before the Erie St. Clair CCAC. We are currently awaiting for the CCAC to advise of the name and contact information for its nominee. Once this information is provided, we will proceed with scheduling this hearing at a mutually convenient time for the parties.

We look forward to receiving your nominee's name and contact information shortly so that we may proceed with this hearing. If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,



Laralea Stalkie

cc. Rozanna Haynes, Professional Practice Specialist, ONA  
Sheila Gringras, ONA's nominee

## Appendix E



Head Office  
712 Richmond St.  
Box 306  
Chatham, ON N7M 5K4

Siège Social  
712, rue Richmond  
CP 306  
Chatham, ON N7M 5K4

Tel/Tél: 310-CCAC (2222)

[www.esc.ccac-ont.ca](http://www.esc.ccac-ont.ca)  
[www.erieclairhealthline.ca](http://www.erieclairhealthline.ca)

January 23, 2014

Ms. Laralea Stalkie  
1146 Harmony Road  
Corbyville, Ontario  
K0K 1V0

Dear Ms. Stalkie:

**RE: Erie St. Clair Community Care Access Centre; Professional Responsibility Complaint – Independent Assessment Committee – ONA file #201302931**

Further to your correspondence dated January 21, 2014, I am pleased to advise you that the Erie St. Clair Community Care Access Centre's nominee for the Independent Assessment Committee panel is Mr. James Taciuk. As requested, his contact information is as follows:

Mr. James Taciuk  
Senior Manager, Client Services - Contact Centre and Hospital Transfer Team  
Central Community Care Access Centre  
Tel: 905-895-1334 x2124 | Cell: 905-751-8593  
Email: [James.Taciuk@central.ccac-ont.ca](mailto:James.Taciuk@central.ccac-ont.ca)

I look forward to hearing from you regarding potential hearing dates.

Sincerely

A handwritten signature in cursive script, appearing to read "S. Leonard".

Suzanne Leonard, CHRP  
Director, Human Resources  
Phone: 519-436-2222 ext. 7285  
Fax: 519-436-2430

CC: Margaret Marcotte, Labour Relations Officer, ONA  
Rozanna Haynes, ONA Professional Practice Specialist  
Sue Gelinis, Bargaining Unit President, ONA  
Tricia Khan, Sr. Director of Patient Services  
Kelley Doyle, Sr. Director, Project Management, HR & Organizational Development  
Lucy Coppola, Director of Patient Services  
James Taciuk, Senior Manager, Client Services - Contact Centre and Hospital Transfer Team



**Erie St. Clair Community Care Access Centre**  
**Centre d'accès aux soins communautaires**



**Independent Assessment Committee  
Hearing  
Ontario Nurses' Association / Erie St Clair  
Community Care Access Centre**

**Draft Agenda #2  
Tuesday June 17<sup>th</sup>, 2014**

09:00 – 10:00	<i>Independent Assessment Committee Meeting (Committee Members only)</i>
10:00 – 11:30	Tour of the ESC CCAC <ul style="list-style-type: none"><li>◆Attending: to be determined</li></ul>
<b>1300</b>	<b>Commencement of Hearing: Holiday Inn &amp; Suites Ambassador Bridge, Windsor</b>
13:00 – 13:30	●Introduction and Review of Proceedings by Chairperson
13:30 – 15:00	●Ontario Nurses' Association Submission Presentation <ul style="list-style-type: none"><li>◆Response to questions of clarification by<ul style="list-style-type: none"><li>•Independent Assessment Committee</li><li>•ESC CCAC</li></ul></li></ul>
15:00 – 15:15	Break
15:15 – 16:45	●Erie St Clair CCAC Submission Presentation <ul style="list-style-type: none"><li>◆Response to questions of clarification by<ul style="list-style-type: none"><li>•Independent Assessment Committee</li><li>•Ontario Nurses' Association</li></ul></li></ul>
16:45 – 17:00	●Review of Process for June 18th, by Chairperson
17:00	Adjournment of Hearing

**Independent Assessment Committee  
Hearing  
Ontario Nurses' Association / Erie St Clair CCAC**

**Draft Agenda #2  
Wednesday June 18, 2014**

- |                                       |  |
|---------------------------------------|--|
| 08:00 – 08:30<br><i>members only)</i> | <i>Independent Assessment Committee Meeting (Committee</i>   |
| 08:30<br><b>Bridge, Windsor</b>       | Continuation of Hearing Holiday <b>Inn &amp; Suites Ambassador</b>   |
| 08:30 – 11:30                         | <ul style="list-style-type: none"><li>●Erie St Clair Response to Ontario Nurses' Association Submission<ul style="list-style-type: none"><li>◆Response to questions from<ul style="list-style-type: none"><li>•Independent Assessment Committee</li><li>•Ontario Nurses' Association</li></ul></li><li>◆Discussion</li></ul></li></ul> |
| 11:30 – 12:30                         | Lunch Break  |
| 12:30 – 15:30                         | <ul style="list-style-type: none"><li>●Ontario Nurses' Association Response to ESC CCAC Submission<ul style="list-style-type: none"><li>◆Response to questions from<ul style="list-style-type: none"><li>•Independent Assessment Committee</li><li>•ESC CCAC</li></ul></li><li>◆Discussion</li></ul></li></ul>                         |
| 15:30 – 15:45                         | ●Review of Process for June 19 <sup>th</sup> , by Chairperson  |
| 15:45                                 | Adjournment of Hearing   |
| 16:30 – 20:00<br><i>members only)</i> | <i>Independent Assessment Committee Meeting (Committee</i>   |

*Note: The timing of the agenda is 'fluid'. If the Erie St Clair Response submission/discussion is concluded before lunch, we will proceed with the ONA Response submission/discussion before the lunch break. If the ONA Response submission/discussion concludes before 15:30, the Hearing will adjourn. The Hearing will adjourn at 16:00 at the latest*

# **Ontario Nurses' Association / Erie St Clair CCAC**

## **Draft Agenda Thursday June 19, 2014**

**08:00** Continuation of Hearing **Holiday Inn & Suites Ambassador  
Bridge, Windsor**

**08:00 – 12:00** ●Questions to both ONA and ESC CCAC by IAC

**12:00 – 12:30** ●Closing Remarks and Discussion of Next Steps by  
Chairperson

**12:30** **Closure of Hearing**

*\*\*Independent Assessment Committee Meeting (Committee members only)  
will meet via telephone on Friday June 20<sup>th</sup> at 1000-1100.*

## **Appendix G: List of Attendees from Erie St. Clair CCAC and the Ontario Nurses' Association.**

### **Day 1: June 17, 2014**

#### **ESC-CCAC**

1. Nancy Jammu-Taylor, Legal Counsel
2. Cheryl Zaffino, Patient Service Manager
3. Nadine Monroe-Wakenell, Patient Service Manager
4. Kelley Doyle, Senior Director, Project Management, HR and Organizational Development
5. Deb Johnson, Director of Business Process Change
6. Lucy Coppola, Director of Clinical Services
7. Tricia Khan, Sr. Director of Patient Services
8. Suzanne Leonard, Director of Human Resources

#### **ONA**

1. Rozanna Haynes, Professional Practice Specialist
2. Cathy Bourque, Bargaining unit President
3. Sue Gelinas, Care Coordinator Intake Windsor Site
4. Beth Bridgeman, Care Coordinator, Short Stay Windsor site
5. Lorrie Daniels, Professional Practice Specialist
6. Marsha Sparnaay, Care Coordinator, CI Team
7. Kimberley Evans, Care Coordinator, adult, chronic/complex Team
8. Janet Griffin, Care Coordinator, Sarnia-Lambton Site Rep
9. Krisann Kindrachuk, Care Coordinator
10. Beth Reid, Care Coordinator, Oncology
11. Nicole Butt, Litigation Team
12. Margaret Marcotte, Labour Relations Officer
13. Karen Bertrand, Regional VP
14. Dianne Leclair, Regional VP
15. Sandra Sprenger, Bargaining Unit President HNHB CCAC

### **Day 2: June 18, 2014**

#### **ESC-CCAC**

1. Nancy Jammu-Taylor, Legal Counsel
2. Cheryl Zaffino, Patient Service Manager
3. Nadine Monroe-Wakenell, Patient Service Manager
4. Kelley Doyle, Senior Director, Project Management, HR and Organizational Development
5. Deb Johnson, Director of Business Process Change
6. Lucy Coppola, Director of Clinical Services
7. Tricia Khan, Sr. Director of Patient Services
8. Suzanne Leonard, Director of Human



### **ONA**

1. Rozanna Haynes, Professional Practice Specialist
2. Cathy Bourque, Bargaining unit President
3. Sue Gelinas, Care Coordinator Intake Windsor Site
4. Beth Bridgeman, Care Coordinator, Short Stay Windsor site
5. Lorrie Daniels, Professional Practice Specialist
6. Marsha Sparnaay, Care Coordinator, CI Team
7. Kimberley Evans, Care Coordinator, adult, chronic/complex Team
8. Janet Griffin, Care Coordinator, Sarnia-Lambton Site Rep
9. Krisann Kindrachuk, Care Coordinator
10. Beth Reid, Care Coordinator, Oncology
11. Nicole Butt, Litigation Team
12. Margaret Marcotte, Labour Relations Officer
13. Karen Bertrand, Regional VP
14. Dianne Leclair, Regional VP
15. Sandra Sprenger, Bargaining Unit President HNHB CCAC

### **Observers for ONA**

16. Janelle Rivard
17. Chirstina Sasso
18. Renee Marshall
19. Stephanie Phillips
20. Gail Eldracher
21. Denise Granados
22. Becki Beethem
23. Mary Ellen Boutrin
24. Jackie Werstein
25. Danielle Bauer

### **Day 3: June 19, 2014**

#### **ESC-CCAC**

1. Nancy Jammu-Taylor, Legal Counsel
2. Cheryl Zaffino, Patient Service Manager
3. Nadine Monroe-Wakenell, Patient Service Manager
4. Kelley Doyle, Senior Director, Project Management, HR and Organizational Development
5. Deb Johnson, Director of Business Process Change
6. Lucy Coppola, Director of Clinical Services
7. Tricia Khan, Sr. Director of Patient Services
8. Suzanne Leonard, Director of Human

## **ONA**

1. Rozanna Haynes, Professional Practice Specialist
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9. Krisann Kindrachuk, Care Coordinator
10. Beth Reid, Care Coordinator, Oncology
11. Nicole Butt, Litigation Team
12. Margaret Marcotte, Labour Relations Officer
13. Karen Bertrand, Regional VP
14. Dianne Leclair, Regional VP
15. Sandra Sprenger, Bargaining Unit President HNHB CCAC
16. Renee Trombley
17. Denise T