February 18th, 2014

Lobbying Queen's Park: Nurses And CHCs

Ted Ball

Over at the headquarters of the **Registered Nurses' Association Of Ontario** (RNAO) on Pearl Street, a counter-strategy is evolving about how to deliver primary care and support services to meet the needs of our population with evidenced-based best practices. Their process includes looking at the evolving system through a lens that enables the full scope-of-practice of RNs, while also expanding the use of *Nurse Practitioner-led Clinics* and exploring concepts like the "*Care Co-ordinators*" in the delivery of primary care services.

Over the past five years, the RNAO has conducted a number of very effective and influential advocacy campaigns for health system reform on such vital issues as primary care, air quality, health promotion and the transformation and expansion of community care services. All of these advocacy campaigns reflect the heart-felt values of their nurse members.

They have produced some top-notch, values-based, leading-edge public policy and nursing practice guidelines in their published reports: "***Client-Centred Care"***, "***Facilitating Client-Centred Learning"*** and "***Strategies To Support Self-Management In Chronic Conditions"***.

These paradigm-shifting perspectives -- all presented with compelling, solid evidence -- are now starting to have an impact on the thinking of a number of key people/groups in the healthcare sector.

For their part, the RNAO argues that much of our CCAC costs are for "unnecessary bureaucracy". They suggest relocating the *Case Managers* to primary care settings to save what they say is $160M annually in administration costs. While more streamlined administrative costs is one part of the RNAO's goal, they say they are primarily focused on quality patient care, and evidence-based best practices.

Says RNAO CEO **Doris Grinspun**, "We are proposing that the CCACs evolve into moving the case managers that they currently have -- 3,500 of them -- directly to work in primary care to actually support patients in the community. Then, evolve the rest of the CCAC administration into the LHINs to actually provide health system planning for all the services, including primary care, and including home health care."

Over 150 RNAO members will descend on Queen's Park on February 27th for their annual **Nurses' Lobby Day**. Nurses are now advocating for their three-year plan, ***Enhancing Community Care for Ontarians*** *(ECCO)* which proposes that interprofessional primary care

organizations -- such as Community Health Centres (CHC), Nurse Practitioner-led clinics (NPLC), Aboriginal Health Access Centres (AHAC) and Family Health Teams (FHT) -- expand their reach and role over the next three years, with the support of a temporary **LHIN-led Primary Care Transitional Secretariat** to organize local geographic primary care networks.

The RNAO's ECCO model proposes that by 2015, primary care organizations should provide complete care co-ordination and health system navigation for all Ontarians -- including the referral for home health care and support services, thus eliminating the need for CCACs.

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

So, by the end of **Nurses' Lobby Day**, most MPPs will have had a quality one-on-one conversation with a passionate and articulate RN (from their riding) who will explain how the RNAO's ECCO model benefits patients.

Having worked with nurses on strategy and operational issues for the past 20 years in the *Balanced Scorecard* development process with hospitals and CCACs, I think I have a fairly good understanding of their values, beliefs and passions.

Today, RNAO really does reflect their rank-and-file members. That's why they have grown from 17,728 members in 2002, to 36,000 voluntary members by 2013 -- an increase of 103 percent.

So, here is an organization with remarkable staff and board leadership. Even if you don't like them because they are mostly focused on the nurses' perspective, these guys really have learned how to be effective in our complex political/policy environment.

They do something very important: they speak "**truth to power**" and, as a result, they have real influence on how decision-makers think about the key healthcare issues.

Feisty RNAO CEO **Doris Grinspun** -- who along with her President and thousands of engaged members of RNAO speak out passionately on behalf of the nursing profession. Indeed, **Grinspun** has become a major force for evidence-based health policy and for best practice reform initiatives that would truly benefit patients -- while at the same time -- enhancing the full scope-of-practice of RNs. She tells it like it is -- the whole truth. As a result, all three political parties listen respectfully to Doris, and to the RNAO's message.

Other groups are critical of the RNAO's razor focus on just nurses -- rather than on the whole healthcare team. However, most are very aware of the rising influence of nurses. The hard, cold, political fact is that our three provincial party leaders want to reach out to this significant voting block of 115,000 Ontario RNs and their families. So they listen carefully to Doris because she is a passionate, values-focused advocate who can, and will, mobilize these nurses politically.

As we witness the traditional "dances of the dinosaurs" with hospitals and doctors, another very entrepreneurial and highly strategic force for progressive health policy reforms has been unleashed by the ***Ontario Association Of Community Health Centres***, under the leadership of **Adrianna Tetley**, their hard-working, highly-strategic, bottom-line CEO.

Originally set up under **Bill Davis'** "Red Tories", *Community Health Centres* had an initial mandate to serve "at risk" populations -- particularly the poor. However, the holistic, more integrated approach to primary care was seen as the model that would ultimately emerge as a focal point for primary care service delivery, while grand-fathering many of the solo GPs over however many decades it would take.

The long-term plan in the early '80's was to incrementally grow the CHC sector, and to measure its performance for gradual expansion into middle class communities. Thirty years later, we still only have 77 CHCs serving just 4 percent of the population. That's because McGuinty and the OMA favored *Family Health Teams* to CHCs.

Tetley has the good fortune of representing a sector that produces excellent health outcomes -- in a fairly cost-effective manner. The CHC sector ought to have a bright future because of their high patient/client satisfaction rates -- which are directly related to their fully-integrated, multidisciplinary team approach to holistic primary healthcare services.

AOHC places a lot of emphasis on building the internal capacity of CHCs to be excellent at quality, service and the patient/client experience. As a result, today there are many more examples of administrative excellence and high quality healthcare services -- along with compassion, caring, commitment and love.

That's why CHCs are becoming a "high-performing" component in the healthcare services delivery system. Addressing the CHCs at their annual meeting, **Deb Matthews** said: "*What you do is not just the right thing to do for people in need, it is the right economic choice for the government to make*."

Recent studies by the *Institute For Clinical Evaluative Studies* (ICES) demonstrated that the *CHC Primary Care Model* is by far the best performer among all of the other primary care models. They even take the sickest -- 32 percent of CHC clients have multiple diagnosis. Another study by *Elisabeth Bruyère Institute*, found that CHC model provides "superior services in chronic disease prevention and management, as well as superior health promotion services".

Hello? Isn't that what we will need more of in the future?

In terms of health system transformation, if primary care is to become the "*hub of the system*", CHCs need to be a key strategic sub-sector that ought to grow by at least 8 percent per year for the next three years -- to achieve at least 24 percent growth (prior to reducing hospital budgets) as the government makes good on their commitment to "shift resources to primary care, and to the community sector".

This "parallel system" would only co-exist for a short two to three-year transition period. That means that health system operating costs will be much more expensive in the initial set-up, and start-up phases of transformation. For a brief period, we would have both the developing

community sector, and the hospitals (frozen at "0"), in full operation -- until the appropriate community services are fully in place -- and only then reducing the institutional budgets within each community's ***Integrated Health Service Plan***.

However, the realities of minority government -- now, and after the next election -- means that nobody is actually planning the "transformation" in any sort of strategic way.

Yes, that's right. There is no plan. Surprise! Welcome to Ontario. We don't have a plan for the future.

I told you, people with weak stomachs need to avoid observing two things: the making of sausage, and the making of public policy -- because there is a lot of crap in both those products.

So the government mostly just "talks" transformation policy -- and sincerely hopes for it to occur one day -- while maintaining as much of the status quo as possible, for now. When you are in a minority government situation, its smart politics to be on both sides of the *Status Quo/Fundamental Transformation* debate.

Nevertheless, beyond the "politics of survival" for the **Spring Budget 2014**, is the whole ugly truth about the province's true economic circumstances -- and the realities of both pending funding cutbacks, and the pressing need for the reallocation of resources between the institutional and community sectors.

In the meantime, the OACCAC in its fourth policy paper, "launching the conversation", has suggested that the government contract out their policy responsibility to a Commission or "Committee Of Experts" who would report after the election -- so the current government can say: "It is being studied".

But that won't work. In the next election, voters will want to know from each political party: **Do you support user fees, and means-tested private pay for home care services, or not**?

And, if not, how do you propose to pay for expanded homecare services: by reducing some of the estimated 30% waste in our $48 billion system; by shifting resources from acute care services to home and community support services, or by some combination of these?

Next week I'll tell all about the ***Doctor's Lobby***.