~~Don't~~ Sweat the Small Stuff

Chapter 19 – CCACs/Home Care the Bubble Wrap of the Health Care System

The home care system in Ontario has had a very checkered past and continues to be in a state of flux. As a matter of full disclosure I have been the CEO of two Community Care Access Centres. I was the original CEO in Kenora Rainy River when the CCACs were created and a decade later I was the CEO of the Waterloo Wellington CCAC after the amalgamation of CCACs to reduce the number to 14 to bring them in line with the LHIN boundaries. The ongoing story for CCACs or Home and Community Care Services, as it is now called, is one of mis-steps and missed opportunities.

The creation of the Community Care Access Centres held promise. It was the first time that the home care sector would be a key player in the health care system and not just an afterthought. Home care was a multi-billion dollar sector and when the CCACs were created this critical mass came together to provide the possibility of a unified voice and delivery system for Ontario's home care sector.

Almost thirty years ago it was recognized that more responsive and coordinated community services were needed to keep people out of hospitals and to delay their admission to LTC. The particular model chosen by the government of the day hoped to spur competition amongst providers to reduce costs. My own more cynical approach was that the desire was to have a lot of providers across the province competing with one another and creating a sector that would be difficult for unions to organize.

The idea of competition in the sector was not necessarily a bad thing. Contracting arrangements that had been in place for decades had led to a lack of due diligence around costs that were being charged to the home care program. In some cases the per visit rate paid was cut in half and the services provided by the new contractors were on par or superior to the service that had traditionally been provided. Certainly this represented a better use of public funds. The challenge became the structure required to set up bidding for services, the management of those contracts and the ongoing management of market shares. CCACs spent inordinate amounts of time and money on contracting and managing contracts. The bidding process itself was detailed and ensured fairness with third party monitors, the two-envelope system where pricing was not even considered until the quality of the service and the provider could be established. There were appeal mechanisms and other safeguards built into the bidding system. The unintended consequence of this was that the cost to respond to a major RFP could easily hit $100,000 thereby blocking out many small providers across the province and consolidating care provision with the larger providers across the province.

Another benefit that was never fully utilized was the development of a client software system across all CCACs. Collectively there were 236 CCAC offices across the province, all using the same software to manage their patients. (At the time CCACs provided care to over 600,000

people – now close to a million clients each year.) This software system allowed patients to be transferred from one CCAC to another if they moved or had to access service elsewhere. At the time it was the only electronic patient record that covered an entire sector and the entire province. There were great opportunities to use this system as the base for providing chronic disease management, identify people at risk and proactively deal with issues and collect data at a provincial level. Unfortunately none of this happened.

The Ministry did not seem to demand more of the CCACs and given the fact that they already had the frail and elderly in the province on their caseloads, it would have made sense to have the CCACs deliver chronic disease management services and coordinated services to manage complex patients in the community. The Ministry often decided to set up different programs and models to deal with the various cohorts of patients. These were often limited to some geographies so they were not available to all Ontarians and they tended to cost more so they were not scalable. Overall there was not a standardized approach but once more a patchwork quilt of services.

I was never a fan of the RAI-Home Care assessments. Being in the CCAC world or the Home and Community Care Services, (the renamed CCACs) my dislike of the RAI assessment tool amounts to heresy. Ontario is heavily involved in RAI assessments and has been for 30 years. On paper a standardized assessment tool will make sure assessments are done in a highly structured manner that should provide decision makers with the right information to make the right decisions seems to make sense. The home care version of RAI does score well. One might wonder why I would not wholly endorse this approach - I have three reasons. First is the bureaucratic nature of the tool and the use of degree RNs to administer the RAI assessment. When I was involved, we had 4,000 degree RNs who worked as Case Managers across the system. This seemed like a sub optimal use of great talent. Second the assessment is supposed to be standardized and the results not "gameable". I accompanied a case manager to a home to do an assessment on a gentleman who was in his early 70s. His wife wanted him in LTC. Once completed, the assessment indicated that he did not warrant being in LTC. The case manager asked the wife about her husband's slipping on the wet bathroom floor the previous week. Yes that had happened - she indicated in the assessment that he had walking difficulties and presto he now qualified for placement in a long term care facility.

Lastly it seemed that the use of RAI was less for the clients and more for centralized data keeping and analysis by academics and researchers. I had several Case Managers who dutifully filled out the RAI assessments but told me they already knew what the client needed and the assessment was just added paperwork for them. We now have close to a million people receiving care in the community and the RAI is supposed to be done every six months and takes about 2 hours to do. 1 million X 2 times per year X 2 hours X $60 per hour = $240 million per year on RAI assessments alone. The amount might be double that amount when travel, overhead, rent, etc. are added in. In defense of the RAI I have a sister-in-law who was an intake case manager and was responsible for patients coming from the acute sector. She found the RAI allowed her to accurately identify the services required. Due to geography this was done virtually and RAI provided the right information to determine what services the client needed

upon discharge from the hospital. So RAI may have benefits for some clients but perhaps not all home care clients.

There was always this zombie idea that CCACs or Home and Community Care should be part of the LHIN. I argued against this on two different occasions as I saw that it completely changed the role of the LHIN. As a system planner and funder the LHINs needed to be honest brokers, not putting one sector above any other sector but remain partial and fair in their dealings and decisions. As soon as the LHIN became a service provider they lost the position of system planner as they were simply now another service provider that competed with other system providers for scarce resources. The Ministry finally got their way and the sector has suffered ever since. The LHIN reputations also took a hit and it was clear that the original promise of the LHINs as system planners and funders would never be realized.

If the Ministry wanted to effectively reorganize the system they should have taken the 4,000 case managers and embedded them in primary care settings. Basically any practice of three physicians or more could have had a CCAC case manager in their office. This would have done more to coordinate care and integrate services than moving the CCAC sector to the LHINs where home care expertise and clinical oversight were not part of the LHIN. Currently the model tends to work somewhat in urban settings but in rural and northern settings, homecare is now almost non-existent putting additional pressures on hospitals and LTC facilities. (In small communities home care should be contracted to the local hospitals as they control almost all of the health human resources and have the greatest incentive to provide adequate home care services.)

When I finally left the sector I told my fellow CEOs that we were the "bubble wrap" of the health care system. They thought I meant that that bubble wrap was protective and wrapped around valuables. While that has some meaning, the meaning I was driving at was the reality that bubble wrap was not invented as the fantastic packing material it has become but was invented by an artist to be 3-D wallpaper!

I felt the same way about the CCACs - our true potential was never realized. We were still stuck being 3D wallpaper when we could have been doing so much more.