



**RNAO submission on the new  
draft edition of the CAN/HSO  
34015:2026 (E) *Primary Health  
Care Services* standard**

**April 29, 2026**



The Registered Nurses' Association of Ontario (RNAO) is the professional association representing more than 57,250 registered nurses (RN), nurse practitioners (NP) and nursing students in all roles and sectors across Ontario. Since 1925, RNAO has advocated for healthy public policy, promoted excellence in nursing practice, increased nurses' contribution to shaping the health system, and influenced decisions that affect nurses and the public we serve.

## Introduction

RNAO welcomes the opportunity to provide feedback on the draft edition of the CAN/HSO 34015:2026 (E) *Primary Health Care Services National Standard*, further to a Health Standards Organization (HSO) consultation. RNAO's analysis of the new standard draws heavily on the association's leadership in evidence-based practice and advocacy to strengthen primary care delivery. Our work includes:

- Developing more than 50 evidence-based [best practice guidelines](#)
- Advocating for health system transformation, anchored in team-based primary care, as outlined most recently in RNAO's [Enhancing Community Care for Ontarians 4.0](#) report, and in earlier publications including [Primary Solutions for Primary Care](#) (2012) and [Enhancing Community Care for Ontarians 1.0](#) (2012), [2.0](#) (2014) and [3.0](#) (2020).
- Advocating for health-system improvement by developing [political advocacy materials](#).
- Advocating for full-scope practice for nurses of all classifications in primary care to improve access, quality and continuity of care.

RNAO applauds HSO's proposed draft. The draft has many strengths, including:

- an equity-centred approach
- a focus on primary health care services that are accessible, people-centred and grounded in social participation, continuous, comprehensive, and coordinated
- the endorsement of interprofessional team-based care
- acknowledgement of the importance of digital health infrastructure
- acknowledgement of environmental stewardship

RNAO recommends building on the strengths of the draft by:

- explicitly establishing that primary care services should be publicly funded, universally accessible and not for profit
- requiring interprofessional team-based care as the preferred model of publicly funded primary care delivery
- explicitly enabling RNs, NPs and RPNs to practice to full scope
- strengthening accountability for patient access and attachment by requiring the collection and reporting of disaggregated demographic and access data to measure equitable access
- developing activities that encourage workforce retention and healthy work environments
- expanding the role of primary care in coordinating care transitions
- incorporating targeted edits to improve clarity

## Missing concepts

RNAO has identified missing concepts and gaps that should be addressed within the draft national standard to improve access to high-quality primary care, outlined in the following table.

Missing concepts or gaps	RNAO's rationale
<p><b>1. Explicitly establishing that primary care services should be publicly funded, universally accessible and not for profit</b></p> <p>The draft standard does not explicitly address the need to maintain a high-quality publicly funded health system.</p>	<p>To achieve high-quality, equitable and cost-effective care for all, RNAO maintains that primary care services should be delivered through a publicly funded, not-for-profit model. Such a system, when adequately resourced, promotes universal access to care regardless of ability to pay (1). At a minimum, public funding ensures patients can obtain primary health care services without user fees.</p> <p>Not-for-profit delivery is consistently linked to better health outcomes and lower costs (1,2). In contrast, profit-driven health systems create barriers to equitable access and are associated with compromised quality of care, higher mortality rates and increased costs (3–8).</p> <p>For this reason, RNAO recommends that the draft national standard explicitly speak to publicly funded primary care services within section 1, <i>Population health and service design</i>.</p>
<p><b>2. Requiring interprofessional team-based care as the preferred model of publicly funded primary care delivery</b></p> <p>The draft appropriately supports team-based care, but it should go further and establish interprofessional team-based care as the preferred and expected model for publicly funded primary care delivery.</p>	<p>RNAO recommends universal attachment to a family physician or nurse practitioner ideally delivered through an interprofessional team-based model. Team-based primary care improves access, increases continuity, supports larger patient panels, strengthens chronic disease management and improves outcomes.</p> <p>The standard should make clear that primary care should not rely on a single-provider model where comprehensive care depends on one profession alone. Community health centres,</p>

	<p>nurse practitioner-led clinics, Indigenous-led models, nursing stations, family health teams and other team-based approaches should be recognized as preferred delivery models.</p> <p>RNAO recommends strengthening Section 4, <i>Interprofessional Team-Based Care</i>, to establish interprofessional team-based care as the default model of high-quality primary care.</p>
<p><b>3. Explicitly enabling RNs, NPs and RPNs to practice to full scope</b></p> <p>Although the draft national standard supports interprofessional teams, it does not sufficiently articulate the role of nursing or require organizations to remove barriers that prevent nurses from practicing to full scope.</p>	<p>RNs, NPs and RPNs are central to access, assessment, chronic disease management, health promotion, care coordination, virtual care, outreach, mental health support, system navigation and population health (1).</p> <p>Without explicit requirements, team-based care risks remaining physician-centred in practice despite interprofessional language in principle.</p> <p>RNAO recommends that Section 4, <i>Interprofessional Team-Based Care</i>, require organizations to demonstrate how team members, particularly RNs, NPs and RPNs, are enabled to practise to their full legislative and professional scope, including independent clinical decision-making, leadership responsibilities, chronic disease management, care coordination and preventive care.</p>
<p><b>4. Strengthening accountability for meaningful patient access and attachment to an NP or a family doctor by requiring the collection and reporting of disaggregated demographic and access data to measure equitable access</b></p> <p>RNAO commends the inclusion of key primary care performance indicators within Section 5 of the draft national standard, <i>Performance</i></p>	<p>Incorporating the collection and reporting of disaggregated demographic and access data to primary care organizations' performance measurement plan would strengthen accountability for equitable access across populations and regions.</p>

<p><i>Measurement and Continuous Quality Improvement.</i> Examples included: attachment rates, access to same or next day appointments, and after-hours access. However, the draft standard lacks explicit direction on collecting and reporting of disaggregated demographic and access data as a key measure of equitable access.</p>	
<p><b>5. Develop activities that encourage workforce retention and healthy work environments</b></p> <p>Section 4.1.7 of the draft standard describes the importance of teams measuring and monitoring effective team functioning to strengthen teamwork through methods including role clarity, communication plans, adherence to workflows, and leadership practices. In addition, section 5.1.7 discusses the importance of measuring and monitoring the experiences of the primary care workforce related to care delivery and working conditions.</p> <p>However, the draft standard does not explicitly address workforce retention.</p>	<p>The experience of health-care providers is a core determinant of high-quality, equitable and sustainable health-care delivery, as recognized in the Quintuple Aim framework (9,10). Workforce recruitment and retention are especially critical in primary care, where existing workforce shortages already compromise the goals of universal primary care attachment and timely access to care.</p> <p>A comprehensive standard must therefore address not only how care teams are structured, but also how they are supported, sustained and enabled to remain in primary care over the long term. Without deliberate attention to workforce retention, standards that aim to strengthen primary care risk being undermined in practice. RNAO recommends the draft national standard explicitly incorporate a workforce retention strategy within section 4, <i>Interprofessional Team-Based Care</i>.</p> <p>RNAO recommends a workforce retention strategy that includes measures to:</p> <ul style="list-style-type: none"> <li>• ensure access to benefits and paid sick days</li> <li>• provide mentorship and professional development, including leadership training</li> <li>• support safe and manageable workloads; and</li> <li>• increase funding, schedule flexibility and resources to pursue continued</li> </ul>

	<p>education, professional development and specialty certification</p> <p>Evidence-based elements of healthy work environments that support workforce retention are outlined in RNAO’s <a href="#">healthy work environment best practice guidelines</a>.</p>
<p><b>6. Expand upon primary care’s role in coordinating care transitions</b></p> <p>The draft national standard defines “care transitions” and mentions the term throughout the standard, including in section 3.5.1 related to planning for care transitions and section 5.1.3 related to measuring the integration of services and transition of care between health care providers, health and social services.</p> <p>However, the components of effective care transition coordination are not well defined within other sections of the standard. While the inclusion of <i>HSO 5012 Safe Care Transitions</i> as a normative reference signals the importance of transitions, this draft national standard would benefit from clearer, primary care-specific expectations for care transitions. Reliance on a separate standard without sufficient contextualization risks inconsistent interpretation and implementation across primary care settings.</p>	<p>Care transitions between sectors or services are well recognized as periods of heightened patient vulnerability, where breakdowns in communication, coordination and accountability increase the risk of adverse events, unmet needs, and poorer patient outcomes (11). RNAO views care coordination and system navigation as core functions of primary care, particularly during patient transitions between sectors and services (9). This is especially relevant to individuals with complex needs and those from underserved communities who face a higher risk of adverse events during transitions in care (11).</p> <p>For this reason, RNAO recommends that the draft national standard articulate the primary care role in care transitions within section 3.5, including clear expectations aligned with key elements described in RNAO’s best practice guideline, <i>Transitions in Care and Services</i> (11), such as:</p> <ul style="list-style-type: none"> <li>• collaborating with patients and their support network before, during and after a transition in care</li> <li>• assessing readiness for transition</li> <li>• collaborating with health and social service organizations to implement a formal interprofessional cross-sectoral approach to care transitions</li> <li>• conducting medication reconciliation at the point of transition</li> <li>• providing support to manage needs during and after transition</li> </ul>

## Opportunities to expand on the RUMBA principles

The draft national standard demonstrates alignment with the principles of relevance, understandability, measurability, benefit and actionability/achievability (RUMBA). Opportunities to further strengthen this alignment include addressing the areas identified below.

Identified opportunities	RNAO's rationale
<p><b>1. Opportunity to clarify the definition of the term “organizational leader”.</b></p>	<p>The term “organizational leader” is used throughout the draft standard. RNAO suggests adding a definition of this term to the “Terms and Definitions” section to clarify responsibility for the roles and actions attributed to organizational leaders.</p>
<p><b>2. Opportunity to integrate addiction services within descriptions of mental health care.</b></p>	<p><b>Incorporate addiction into references to mental health services:</b> In the title of section 1.4.4, RNAO recommends revising the wording to “the organizational leaders integrate mental health <b>and addiction</b> services into the delivery of primary health care services”. In section 3.4.3, RNAO recommends including “addiction” under the second bullet point describing the assessment of mental health symptoms and illnesses.</p>
<p><b>3. Opportunity to explicitly include long-term care as a care transition.</b></p>	<p><b>Reference long-term care as a point of care transition in which primary care has a role:</b> in section 3.5.1, RNAO recommends revising the last bullet point to read “plans for care transitions or follow-up after services end, including home care, <b>long-term care</b>, and palliative or end-of-life care if applicable”.</p>

## Strengths

The draft national standard has several strengths that support the delivery of high-quality primary care services, outlined in the following table.

Identified strengths	RNAO's rationale
<p><b>1. The establishment of equity, diversity, and inclusivity principles as a foundation for primary health care delivery.</b></p>	<p>Across Canada, individuals with lower socioeconomic status, Indigenous peoples, sexual and racial minorities, immigrants and those with functional limitations experience poorer health outcomes and living conditions (12).</p> <p>RNAO envisions an equitable health-care system that improves health for all and decreases avoidable health gaps between groups (1). RNAO asserts that health equity begins in primary care and that primary care serves as a key access point for connecting individuals, including those who are marginalized, to the services they need (1).</p> <p>To advance health equity, the draft national standard should include expectations that support proactive outreach to marginalized populations, accountability for reducing health disparities, cross-sectoral collaboration and the delivery of person-centred care approaches that respect individuals' unique needs, experiences and goals (1).</p>
<p><b>2. The clear emphasis on primary health care services that are accessible, people-centred and grounded in social participation, continuous, comprehensive and coordinated.</b></p>	<p>RNAO states that a primary care sector must be accessible, person-centred, continuous, comprehensive and integrated (1). These components are set out below.</p> <p><b>Accessible:</b> RNAO maintains that for primary care to be accessible it must extend into a range of settings, including non-traditional spaces, be delivered through an interprofessional care model where providers work to their full scope, and provide comprehensive, continuous and coordinated care (1).</p> <p><b>Person-centred and continuous:</b> RNAO asserts that primary care should support continuous and person-centred care where</p>

Identified strengths	RNAO's rationale
	<p>providers recognize clients as whole persons, contextualize care within clients' unique lives, and partner with individuals in care planning and decision-making related to the delivery of their own care (1). RNAO supports universal attachment to improve continuity of care.</p> <p><b>Comprehensiveness:</b> RNAO views disease prevention, health promotion, diagnosis, treatment and management of health needs as key components of comprehensive primary care (1).</p> <p><b>Integrated and coordinated:</b> RNAO believes integration of care is essential, ensuring smooth transitions and coordination across sectors, with primary care teams leading care planning and navigation (1). RNAO further identifies comprehensive care as requiring clear connection and coordination between primary care teams and the broader health and social systems (1).</p>
<p><b>3. The establishment of interprofessional team-based care, with team members enabled to practise to full scope, as the preferred model for delivering high-quality primary health care.</b></p>	<p>RNAO recommends that universal attachment to a family or nurse practitioner be ideally provided through an interprofessional team-based model (1). Interprofessional team-based primary care contributes to increased patient access, increased productivity, larger panel sizes, more patient visits and improved outcomes, especially for those with chronic conditions (1,13–15). In particular, nurses working to their full scope of practice as part of a primary care team promote more integrated, efficient, and accessible health care (3, 9, 10).</p>
<p><b>4. The acknowledgement of digital health infrastructure as an essential element of care delivery.</b></p>	<p>RNAO recognizes the optimization of digital health technologies as an essential enabler of accessible, integrated and person-centred primary care (1). The collection and shared use of health data across sectors and settings</p>

Identified strengths	RNAO's rationale
	<p>through digital health technologies support decisions and enhance accountability, as reflected in a recent RNAO best practice guideline, <i>Clinical Practice in a Digital Work Environment</i> (18). Improving access to population health data and personal health information further supports better integration, collaboration among health providers and persons receiving care and improved patient outcomes – especially during care transitions (1).</p>
<p><b>5. The acknowledgement of environmental stewardship and the importance of assessing environmental determinants of health as part of primary care delivery.</b></p>	<p>The impact of climate change is recognized across many domains including ecosystems, human health, and the spread of disease. Rising temperatures are a key indicator of climate change and its health impacts. In Canada, the annual average temperature has increased at approximately twice the global average rate, with even higher increases in northern Canada, and 2024 joined 2010 as among the warmest years on record (19).</p> <p>RNAO further recognizes that storms, freezing rain, flooding, tornadoes, wildfires and other climate-related events contribute to morbidity and mortality through both immediate injury, disruptions to health-care delivery, evacuation and chronic disease (1).</p> <p>Accordingly, environmental stewardship is identified as an essential consideration in primary care settings to support efforts to reduce the sector's carbon footprint. In addition, consideration of the impacts of climate change includes assessing individuals for the effects of environmental determinants of health on overall health and wellbeing (9,20).</p>

## Conclusion

Thank you for the opportunity to provide feedback on the draft edition of the HSO's Primary Health Care Services National Standard. We appreciate the opportunity to contribute and commend the development of a primary care standard that aligns strongly with RNAO's vision for equitable, accessible, people-centred, continuous, comprehensive and integrated primary care.

Addressing the additional elements outlined in this submission would further strengthen this alignment and support the consistent delivery of high-quality, person-centred primary care across Canada. RNAO welcomes the opportunity to meet with the HSO to discuss this feedback and review future revisions to the draft standard.

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