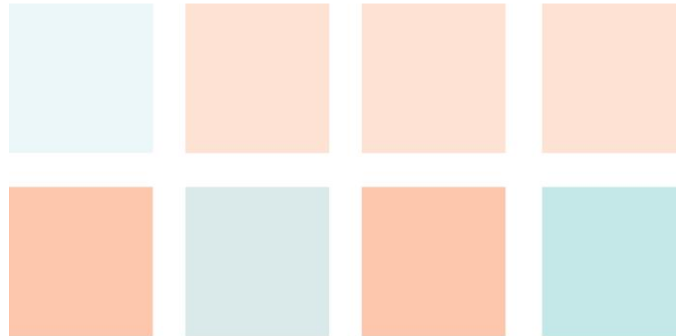
RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

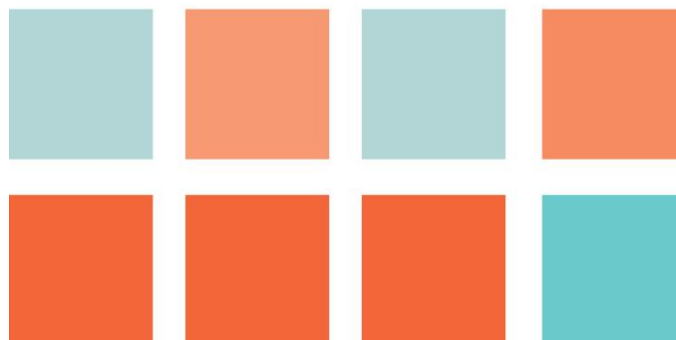


Connecting People to Home and Community Care Act, 2020

Home Care Guarantee for the People of Ontario

RNAO's Response to *Bill 175*: Submission to the Standing Committee on the Legislative Assembly

June 17, 2020



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Summary of RNAO recommendations:

An integrated and coordinated health system that delivers person-centred high-quality care

1. Ensure all amendments and additions to the *Connecting Care Act, 2019* are consistent with the expansion of the Ontario Health Teams (OHT) as part of advancing the broader health transformation agenda to serve all Ontarians and achieve the Quadruple Aim in our health system.

2. Eliminate the current home care delivery business models that are transactional and fee-for-service. Instead, implement models that ensure care and caregiver continuity and emphasize expert clinical and relational care. For this to succeed, build a stable workforce by ensuring 70 per cent of staff are employed full-time and are compensated in a way that matches the hospital sector.

3. Immediately transfer the 4,500 RNs currently working as care coordinators in LHINs with the related funding – inclusive of compensation – to primary care and other community-based organizations, maintaining their contracts with compensation, benefits, and seniority intact.[1]

4. Broaden the list of care-coordination functions in new regulation under the *Connecting Care Act, 2019* to include: (a) connecting patients to necessary social supports and services, and (b) reaching out to non-traditional settings (i.e. shelters, streets, and correctional facilities) accounting fully for the impact of social determinants of health on the lives of persons in local communities.

5. Award contracts for home-care providers that can deliver a broad range of nursing and support care services 24/7 to avoid fragmented care.

6. Award contracts with a preference for home-care agencies that are Best Practice Spotlight Organizations, as they have proven to deliver better health, clinical and satisfaction outcomes for Ontarians.

Improved and equitable access to home and community care services

7. Increase the public funding to home care services by 20 per cent to enable increased access to home care.

8. In keeping with the Ontario Health Teams framework, ensure any dollars saved from increased integration, care coordination and better outcomes are re-invested into additional access to home care services for Ontarians and not to profit-making.

9. Guarantee an expanded publicly-funded basic basket of home and community services with qualifying criteria to ensure improved and equitable access for all Ontarians, regardless of geographic location. For this, engage in full consultation on the types and definitions of "home and community care services" to be included (i.e., nursing, personal support, homemaking, etc.)

10. Ensure OHTs and health-service providers are accountable to needs-based funding that follows Ontarians in an efficient and person-centred manner.

11. Expand technology in the home care environment—including virtual care that is safe and secure—by developing a robust set of quality standards that guides the use of technology and outlines virtual care as an adjunct to in-person care and not as a replacement.

Transparent oversight and public accountability

12. Engage in comprehensive public consultation on the proposed oversight model for any new care settings (including residential congregate care) to ensure definition, criteria and standards are deliberated with the safety of Ontarians prioritized.

13. Develop a transparent, detailed and phased plan for the dissolution of LHINs to limit interruption to vital home and community care services for persons in Ontario that is communicated to the public and implemented immediately.

14. Embed the *Patients' Bill of Rights* in legislation—not in regulation as proposed—and allow a minimum of 60 days for the public and stakeholders to comment on the draft proposal for the new *Patients' Bill of Rights*.

15. Strengthen a clear accountability system in home and community care and maintain the minister's oversight over compliance of the *Patients' Bill of Rights* in legislation, with the ability to approve, deny, or terminate home care agencies based on their assessment.

16. Add the same complaints and appeals processes under the existing *Home Care and Community Services Act,* 1994 legislation to the *Connecting Care Act, 2019* and halt plans to shift these processes to regulation.

Introduction

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing 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' contributions to shaping the health system, and influenced decisions that affect nurses and the public they serve.

RNAO welcomes the opportunity to provide feedback to the Standing Committee on the Legislative Assembly on Minister Elliott's *Bill 175, an Act to amend and repeal various Acts respecting home care and community services*, known in its short title as, *Connecting People to Home and Community Care Act, 2020*.[2]

In this submission, we will address:

- schedule 1 (*Connecting Care Act, 2019* (CCA)) and schedule 3 (*Home Care and Community Services Act, 1994* (HCCSA), repeal and consequential) of *Bill 175*
- the shifting of many key elements of Ontario's home and community care regime from legislation to regulation and policy if *Bill 175* receives royal assent

RNAO offers 16 recommendations and related commentary on *Bill 175* that will also speak to the draft regulatory proposals that were simultaneously posted in February 2020 as part of the government's proposed legislative framework for home and community care modernization.[3]

As we present our recommendations in the current context of the pandemic, it is critical to acknowledge the importance of strengthening home and community care, which has been made even more evident through the glaring deficits in our health-care system during COVID-19. It is a system skewed toward hospital care, to the detriment of solid primary, home and community care. Our vulnerable populations are bearing the brunt of this imbalance. The modernization of the home and community care regime must reflect lessons-learned from COVID-19 which overwhelmed our long-term care sector and impacted the health of thousands because several primary, home and community care services were deemed 'non-essential.' Basically, our hospital-centric system has resulted in worsening mental health amid isolation, caregiver burnout, a backlog of tests and procedures, increased opioid overdoses, poor chronic disease management, and delayed diagnosis and treatment without preventative primary care screening programs. There is a grave need for policies and legislation that support the infrastructure and resources required at home and in the community for Ontarians to live and age with dignity.

In 2019, the late Dr. Rueben Devlin concluded in his first report as chair of the Premier's Council on Improving Health Care and Ending Hallway Medicine, how the insufficient capacity in community care systems—like home care and mental health and addictions care—contributed to immediate and long-term capacity pressures and the broader hallway health care crisis in

Ontario.[4] Dr. Nora Fayed reminds us that the "inclusion and foresight of community care at all levels will prevent us from overwhelming hospitals downstream" as we reflect on the importance of robust community-based care during and after the pandemic.[5]

On May 12, 2020, RNAO released a landmark report- *Enhancing Community Care for Ontarians (ECCO) 3.0*. This report mobilizes a vision for a health system with a robust community sector that is anchored in primary care.[6] The release of ECCO 3.0 was purposefully timed to commemorate the 200th anniversary of the birth of Florence Nightingale. Nightingale insisted that "the ultimate destination of all nursing is the nursing of the sick in their own homes…".[7] ECCO 3.0 shows how robust home and community care models anchored in primary care and tightly connected with public health, are central to a high performing health system. This is true, always, and also during a health-system crisis. Indeed, during COVID-19 health systems worldwide that deployed quickly – as their first line of defense – the community care sector, performed ahead of others. A case in point is Islas Baleares in Spain, with a population of approximately 1.1 million. This region differentiated itself from the rest of a poorly performing Spain, by activating, first and foremost, its primary care and home care sectors.[8]

The launch of Ontario Health and its now existing 24 Ontario Health Teams (OHT) was the impetus to release the third version of ECCO, to present an integrated model of care delivery inclusive of a robust community care sector and anchored in primary care. ECCO 3.0 if fully aligned with OHTs will undoubtedly advance the Quadruple Aim (patient experience, population health, care team well-being, and cost reduction).[9] [10]

The establishment of the *Connecting Care Act* (CCA) in 2019, with its framework for a connected health-care system inclusive of the introduction of OHTs, was welcomed by RNAO, as are amendments to the CCA that integrate home and community care with the rest of the health system. The recommendations below fit with the ECCO 3.0 model and provide a clear direction forward as we consider *Bill 175* and fully realize the power of OHTs.

Recommendations

An integrated and coordinated health system that delivers person-centred, high-quality care

1. Ensure all amendments and additions to the *Connecting Care Act, 2019* are consistent with the expansion of the Ontario Health Teams (OHT) as part of advancing the broader health transformation agenda to serve all Ontarians and achieve the Quadruple Aim in our health system.

RNAO welcomes Ontario's health system transformation agenda. We especially support the formation of Ontario Health Teams, all of which will achieve the Quadruple Aim in our health system (patient experience, population health, care team well-being, and cost reduction). Better health outcomes are best achieved through a balanced health system that utilizes all sectors for what each does best, has a robust community care sector and is anchored in primary care.[11] Such a health system maximizes the service capability in home and community care.

The *Connecting Care Act, 2019*, designed to advance health-care transformation must indeed do that and be entirely consistent with the move to Ontario Health Teams, stronger integration across all sectors, and a fulsome role enabled for home and community care services. All aspects of the Act must be carefully reviewed to be consistent with health-care transformation such that it becomes an enabling legislation that serves all Ontarians.

RNAO's ECCO 3.0 through its 13 recommendations, provides a blueprint for elements of the Act that will more rapidly progress the transformation agenda. The primary purpose of the *Connecting People to Home and Community Care Act* must be to strengthen and fully integrate home care and community care services within the system. Anything less makes the Act superfluous or worse even – a distraction to privatize home health care services. RNAO will not support the latter, as we believe health is a resource for everyday living and health care is a human right.[12] As such, home care services, as with primary care, hospital care, and indeed all other health services, are a necessity of health and must be universally accessible to all Ontarians.

2. Eliminate the current home care delivery business models that are transactional and fee-for-service. Instead, implement models that ensure care and caregiver continuity and emphasize expert clinical and relational care. For this to succeed, build a stable workforce by ensuring 70 per cent of staff are employed full-time and are compensated in a way that matches the hospital sector.

With strategic deployment of RNs and NPs, proper standards and oversight, home and community care services are better equipped to make decisions related to service needs without others in supervisory roles managing service maximums. The success of health-system transformation and integration depends on the strategic deployment of all nurses – RNs, NPs and RPNs – working to their full scope of practice utilization to improve equitable access to home and community care services. In 2003, RNAO recommended a strategy to attain the 70 per cent full-time employment target, by headcount, for all classes of nurse (RN, RPN and NP) in all sectors and geographic areas, a call with have issued repeatedly.[13] In this report, RNAO highlights that full-time employment status was associated with more job security in home care nurses and lower stress.[14]

Within the home care setting, clinical nurse specialists and nurse practitioners, should play a key role in chronic disease prevention and management, wound care, palliation and end-of-life care of

older adults. Research demonstrates their overall effectiveness in the home, including an impact on positive client outcomes.[15]

Approved home care services must provide 24 hours of service, 7 days a week in nursing, personal support worker and rehabilitation services. Anything less will not enable continuity of care and continuity of care giver, both of which are necessary to support an improved patient experience, provider experience and health outcomes.

3. Immediately transfer the 4,500 RNs currently working as care coordinators in LHINs with the related funding – inclusive of compensation – to primary care and other community-based organizations, maintaining their contracts with compensation, benefits, and seniority intact.[16]

The 4,500 RN care coordinators currently working for LHINs should be smoothly transitioned to primary care settings such as Nurse Practitioner-Led Clinics, Community Health Centres, Aboriginal Health Access Centres and Family Health Teams, where they have the expertise and system knowledge to improve patient experience, provide seamless care, and help ease transitions between care settings. *Bill 175* and associated regulations only specify the care coordination functions and do not provide details on the progression of existing care coordinators in LHINs to OHTs.

At the core of the ECCO 3.0 model (see Appendix A) is person-centred care coordination and health system navigation. RNAO advocates for this role to be anchored in primary care, where persons can be assessed and referred for home care and community support services. In addition, amendments should be made to the *Connecting Care Act, 2019* and associated regulations, to mandate that RN care coordinators make the initial referrals to home-care services and perform the initial home care assessments that lead to the creation of the care plan. Building on the ECCO 3.0 model, system integration is often impeded by the lack of interprofessional team-based care and the lack of RN care coordination in primary care. The majority of primary care physicians (54.7 per cent in 2017) are not connected to interprofessional teams, and care coordination is largely performed by hospitals and the soon-to-be defunct LHINs.[17] The lack of integration in our health system can also be demonstrated by the mere 27 per cent of primary care doctors in Ontario who reported to routinely communicate with their patients' case manager or home care provider about their patients' needs and service, lower than other jurisdictions across Canada.[18]

4. Broaden the list of care-coordination functions in new regulation under the *Connecting Care Act, 2019* to include: (a) connecting patients to necessary social supports and services, and (b) reaching out to non-traditional settings (i.e. shelters, streets, and correctional facilities) accounting fully for the impact of social determinants of health on the lives of persons in local communities.

While RNAO would support home care agencies to become home and community care health service providers (HSPs) and thus perform their certain care coordination functions related specifically to their services, we very strongly urge that the primary role of care coordination be located in primary care as the anchoring of OHTs. As such, we insist that the great majority of the 4,500 care coordinators currently working in the LHINs be transitioned to primary care settings.

We are concerned that the care coordination functions are outlined in the regulatory posting, yet there is no mention of the care coordinator role itself and the detailed expectations for care coordination to be outlined in policy are not currently available.

Vital care coordination functions must be anchored in primary care – within or outside the OHT structures – given that at this time much of primary care is not at this time integrated into OHTs. These functions include assessing patient's needs and determining eligibility for service, developing a care plan that is outcome-based rather than visit-based, coordinating care between providers, and helping the client navigate the system. In addition, the list of care coordination functions must be expanded to provide comprehensive and consistent service for all Ontarians. Functions should include connecting patients to necessary social supports and services and reaching out to non-traditional settings to meet the needs of vulnerable population groups in Ontario.

Adequate housing, stable income, clean environments and sufficient education are social determinants that have an immense impact on overall health status. Laws, regulations, and policies that enable communities to create conditions that support health for all people can only be achieved through intersectoral commitments and collaboration among ministries. "Ontario deserves a better balance between investments for prevention and health promotion and investments for medical treatment, disease management and long-term care."[19] These investments must be directed towards the home and community setting. Upstream approaches focused on early childhood development and chronic disease prevention are examples, and both have lasting economic benefits.[20] In the regulatory proposal under the *Connecting Care Act, 2019*, shelters, hostels, and half-way houses are not included in the list of residential accommodation services and RNAO advocates that we do not overlook the inclusion of these settings in our future care coordination functions and overall provision of community care.

5. Award contracts for home-care providers that can deliver a broad range of nursing and support care services 24/7 to avoid fragmented care.

A key element to enhancing community care services across the continuum of care is reforming the home-care funding model to shift from a per-visit basis to funding baskets that promote a person-centred approach and encompass a range of nursing interventions to ensure continuity of

care and continuity of caregiver.[21] In addition, where possible, the same service provider (home care agency) should provide all types of service required by the patient.

Contracts for home-care should be awarded to providers that can deliver a broad range of services: nursing, personal support and rehabilitation 24 hours a day and 7 days a week (24/7) to avoid fragmented care.[22] The current model finds patients and families receiving home care and service from a variety of individuals from different service providers each of which have a different approach to care, policies and ability to connect to other service providers involved. Such service models result in poor patient and provider experience and numerous gaps in service impeding care goals and health outcomes.

In addition the current funding model based on the short-sighted decision to share contracts for patients across different providers may also mean that those service providers offering a full range of services 24/7 are required to share these services with other providers who may be awarded part of the contract, i.e. nursing from one provider agency and personal support from another; or nursing from one provider agency during the day and from another during the evening and night. This results in the epitome of services that lack continuity of care and care giver. Anything less than full service providers to be awarded contracts and the same service provider to offer the entire required service package to a client is unacceptable to RNAO and should not have to be accepted by the public. The piecemeal approach to care will not enable continuity of care and continuity of care giver, both of which are necessary to support an improved patient experience, provider experience and health outcomes.

6. Award contracts with a preference for home-care agencies that are Best Practice Spotlight Organizations, as they have proven to deliver better health, clinical and satisfaction outcomes for Ontarians.

For more than two decades, RNAO has developed rigorous, evidence-based best practice guidelines (BPG) and provided implementation support to nurses and other health team members, organizations and systems that use them. This enables evidence-based practice with better health, clinical and satisfaction outcomes for persons in all health sectors, including home care. Such results are measured by a robust data system known as NQuIRE (Nursing Quality Indicators for Reporting and Evaluation).

In 2003, RNAO formally introduced its Best Practice Spotlight Organization (BPSO) implementation methodology. To date, more than 600 health-service organizations in Ontario, and more than 500 at the national and international level – including home and community care services – have been designated BPSOs after three years of intense coaching and support for rapid learning in the implementation of evidence-based practice. Data shows that BPSOs deliver better health outcomes, patient and provider satisfaction and cost savings. These results are also evident in BPSOs that cross sectors, such as the Ontario Health Teams, four of which are BPSOs. Only one year into their designation, these BPSO OHTs are already demonstrating greater

integration, clearer co-ordination of services, common client-centred approaches, and attention to evidence across sectors.

There are currently 7 home-care agencies that are established, long-time BPSOs delivering better outcomes for Ontarians. As we move to modernize home and community care, criteria will be necessary to ensure we have the highest quality providers from the myriad of home-care providers that currently provide piecemeal services with little or no attention to evidence-based care. RNAO urges government and its agencies – including Ontario Health – to award contracts with preference to home-care agencies that are BPSOs.

Improved and equitable access to home and community care services

7. Increase the public funding to home care services by 20 per cent to enable increased access to home care.

People desperately want to stay in their homes if at all possible, and they deserve that opportunity. Given the problems with hallway health-care in acute care, very long wait times in long-term care, and the devastating effects of the COVID-19 pandemic in long-term care, it makes sense for the Ministry of Health to increase its funding investment in home care. Indeed, funding in home care as of the 2020-21 budget estimates was slated to only consume 5.5 per cent of Ministry operating expenditures. [23] Home care strengthens persons, communities and the health system by supporting people with special needs to live with their loved ones, aging persons to remain in their homes, and/or assist persons to recover from illness and recover functionality post-hospitalization. In doing so, publicly accessible home care allows us to be more independent and fully engaged in our communities. Ontarians are glad that hospitals and long-term care homes are there if needed, but they are much happier if they don't have to use them. And from a budgetary point of view, Ontario is better off if home care can keep people productive and out of these very expensive facilities.

8. In keeping with the Ontario Health Care Teams framework, ensure any dollars saved from increased integration, care coordination and better outcomes are re-invested into additional access to home care services for Ontarians and not to profit-making.

Ontario has long underinvested in upstream care, including public health and home care. However, despite the benefits not always being immediately obvious, it is far better and cheaper to invest in prevention than it is to reap the consequences of underinvestment, as the COVID-19 pandemic has made painfully obvious.

Any opportunity to redress that imbalance must be seized upon, and savings from doing health care better are a good place to start finding money for home care. Ontario Health Teams are entitled to keep a portion of any savings they make while meeting quality expectations,[24] and

those would best be spent in expanding home care. While expanding access to home care, it must be done in an effective and cost-effective manner. The research into provision of health care and ownership has shown that we get better outcomes at lower cost when we take the profit incentive out of the equation when it comes to health care services. Health care is not like manufacturing; the profit incentive mobilized human ingenuity in perverse ways in health care, as cutting corners in hidden areas raises returns to shareholders, even as it adversely affects outcomes. This is why RNAO does not support corporations – that legally – their first obligation is to shareholders.

The Connecting Care Act, 2019 must be accompanied with a full funding package for expanded home and community care services framework. Not doing so, means giving lip service to expanding home and community care services and enshrines the current system imbalance, in our hospital centric system. Worse even, in the absence of added funding, the new *Connecting People to Home and Community Care Act* can serve as a tool for passive privatization of home care services.

The response to COVID-19 showcased the grave pitfalls of a system that favours one sector over another in terms of public funding, staffing, accessibility, equitable services and full integration. The government must be prepared to award funds to expand the home care services to include a basic home care guarantee that is based on a basket of services that every Ontarian in the province is entitled to, should they need it to continue to live in their home.

> 2) *When determining the funding to be provided to the Agency under subsection (1) for a fiscal year, the Minister shall consider whether to adjust the funding to take into account a portion of any savings from efficiencies that the Agency generated in the previous fiscal year and that the Agency proposes to spend on patient care in subsequent fiscal years in accordance with the accountability agreement.*

Ensure that any savings in Ontario Health Teams resulting from achieving the Quadruple Aim go back to the people of Ontario through better staffing and expansion of services to the OHT catchment area population.

It is imperative then that the *Connecting Care Act, 2019,* include a funding package provided to expand access to home and community care services in equitable ways according to their individual needs—anywhere in the province is central to redress the years of underfunding and under service provision possible in this sector.

9. Guarantee an expanded publicly-funded basic basket of home and community services with qualifying criteria to ensure improved and equitable access for all Ontarians, regardless of geographic location. For this, engage in full consultation on the types and definitions of "home and community care services" to be included (i.e., nursing, personal support, homemaking, etc.)

RNAO is unequivocal in that fact that no matter where we live, Ontarians want to know that they will receive a home care guarantee enabled through a basic basket of health services, inclusive of the home and community care sector. Comprehensive home and community care can help frail persons or those with acute, chronic, palliative or rehabilitative health-care needs to independently live in their community and we must ensure that this we embrace the *Home First* philosophy whenever possible. This requires a paradigm shift in our health system to focus our services on supporting people to stay in the home of their choice, wherever that might be in the province.

The government must engage in full consultation on the types and definitions of "home and community care services" (community support services, homemaking services, personal support services and professional services) prior to passing regulations under the *Connecting Care Act, 2019.* Definitions of community services, community support services, homemaking services, personal support services and professional services are among the key elements moving from legislation in the *Home and Community Services Act, 1994* to regulation under the *Connecting Care Act, 2019* if *Bill 175* is passed. RNAO supports this decision on the contingency that there is ample consultation on the types and definitions of home and community care services prior to being passed. The addition of four new community care services that are currently governed under the LHINs, including aphasia services, pain and symptom management, diabetes education, and psychological services for persons with acquired brain injuries is welcomed.

There are wide and inequitable gaps in access to home and community care in this province depending on where you live and the type of service you need, and our children and youth are not immune to this lack of accessibility when it comes to mental health care. 28,000 children and youth are waiting for as long as 2.5 years for mental health treatment according to a survey conducted by Children's Mental Health Ontario (CMHO) of community child and youth mental health centres.[25] The services are not adequate to meet the growing needs of this vulnerable group of Ontarians and although RNAO is hopeful that the Mental Health and Addictions Centre of Excellence under Ontario Health will be a strong foundation moving forward, legislation serves an important role in the provision of high-quality care with a guaranteed basket of core ervices for our children and youth in the community. Through our partnership with CMHO, we recommend immediately shifting the Mental Health and Addiction Nurses from LHINs into interprofessional primary care teams and local child and youth mental health agencies to ensure increased collaboration between schools and community providers. We must invest in improving the availability and quality of community-based mental health and addiction services for Ontarians of all ages.[26]

10. Ensure OHTs and health-service providers are accountable to needs-based funding that follows Ontarians in an efficient and person-centred manner.

As outlined in Schedule 1 of *Bill 175*: *Connecting Care Act, 2019*:

Section 23.1 (1) If a health service provider or Ontario Health Team provides a home and community care service to an individual, the provider or Team shall not require payment from the individual for the service and shall not accept a payment made by or on behalf of the individual for the service, except as provided for in the regulations.

Patients and their families should be at the core of an interprofessional team (members include but are not limited to nurses, personal support workers, physiotherapists, occupational therapists, social workers, and medical specialists) to provide comprehensive expert care in the home and community. RNAO strongly endorses an integrated health system in which an interprofessional team can partner with the client/person and their family to support them across multiple settings in planning their care, and services should be personalized and driven by the client/person in a collaborative effort with the interprofessional team. An interprofessional team that works in an integrated health system can partner with the person to support them across multiple settings to plan care and services and maintain continuity of care during transitions. Based on a study by a group of Ontario health care experts on the home-based primary care (HBPC) model, the benefits of interprofessional teams in the provision of HBPC include reduction in emergency department visits, hospital admissions and hospital days, fewer admissions to long-term care, improved physical functioning and a reduction in overall costs.[27]

11. Expand technology in the home care environment—including virtual care that is safe and secure—by developing a robust set of quality standards that guides the use of technology and outlines virtual care as an adjunct to in-person care and not as a replacement.

Experts in the field at Home Care Ontario, identify that “robust mobile technology needs to be leveraged and made accessible to frontline home care providers in the most remote locations across the province”.[28] RNAO agrees that technology must be strengthened by OHTs to increase access to vital home and community care services, yet it must be done in a manner preserves the safety, security, and quality of care that Ontarians need and deserve. The expansion of virtual care in home and community care as proposed in regulation under the *Connecting Care Act, 2019* reflects RNAO’s ask in ECCO 3.0 recommending that the government optimize digital health technologies to improve access, enhance integration and support person-centred care.[29]

We applaud the government’s effort to ease collaboration and information sharing between frontline healthcare providers by the proposed amendments to the *Personal Health Information Protection Act, 2004* (PHIPA) included in Schedule 3 of Bill 175.

The definition of “health information custodian” in subsection 3 (1) of the Act is amended by adding the following paragraph: 3. A health service provider or person or entity that is part of an Ontario Health Team and that provides a home and community care service pursuant to funding under section 21 of the Connecting Care Act, 2020.

RNAO supports this critical change to legislation that will allow home care providers and their staff to access patient information in real time at the point of care and allow for timely decision-making, which is increasingly important amid the growing complexity of patient care needs in the home.[30] The RNAO envisions a health system in which technology and virtual care provided by OHTs is standardized across the province with a single set of quality standards to maintain safety and security of patient information and ensure high-quality care.

Transparent oversight and public accountability

12. Engage in comprehensive public consultation on the proposed oversight model for any new care settings (including residential congregate care) to ensure definition, criteria and standards are deliberated with the safety of Ontarians prioritized.

There is a stark lack of accessibility to high-quality home and community-based care in Canada and this is currently illustrated by over 430,000 adults perceiving that their home care needs were unmet and the almost 35,000 on wait lists for a long-term care bed.[31] [32] Further to that, in 2018/2019, only 41.6 per cent of Ontario patients rated their home care coordination and service provider(s) as excellent, which speaks to challenges in meeting the patient experience aim under the Quadruple Aim framework.[33] Dr. Samir Sinha, passionate and respected physician advocate for the needs of older adults, calls for a future in which care for this population is home and community based rather than long-term care home based[34]. RNAO whole heartedly supports this and it aligns with the majority interest of Ontario seniors who want to age at home and in the community.[35]

Ontarians living with disabilities at home and in congregate care settings are at risk during any outbreak including a pandemic due to health challenges making them dependent on care as well as an unstable caregiver workforce.[36] The long standing flaws in our health care system and their inherent risks have been fully exposed by the pandemic. And this legislation drafted prior to the pandemic falls far short of the need for sweeping reforms that can address these flaws in their entirety.

RNAO is advocating for the development of new and renovated care residences for persons with dementia, with special consideration to smaller congregates of up to seven residents per house. We must look to enhanced home and community care to reduce the focus on congregate living arrangements for vulnerable populations because of the inherent danger in such settings in particular related to infection prevention and control.[37]

13. Develop a transparent, detailed and phased plan for the dissolution of LHINs to limit interruption to vital home and community care services for persons in Ontario that is communicated to the public and implemented immediately.

Bill 175 outlines the interim and transitional plan for LHINs to be rebranded as Home and Community Care Support Services with a singular mandate of delivering home and community care, as well as long-term care home placement. Beyond this, the public does not have a transparent, detailed, and phased plan to follow in anticipation of the winding down of LHINs as home and community care transitions into Ontario Health Teams. It is unclear how the functions and positions that are currently under the mandate of the LHINs will transfer to Ontario Health in the upcoming months to years. RNAO appreciates the promise to promote continuity amid this transition with the same contacts and same regional identifiers as existing LHINs, but this must be communicated in a clear plan to those that depend on the home and community care system. And this transition must be carried out in a timely manner.

14. Embed the *Patients' Bill of Rights* in legislation—not in regulation as proposed—and allow a minimum of 60 days for the public and stakeholders to comment on the draft proposal for the new *Patients' Bill of Rights*.

    Schedule 3 of Bill 175 provides for the repeal of the Home Care and Community Services Act, 1994, and allows for the repeal of select provisions on different dates.

RNAO is concerned by the decision to move the patient Bill of Rights from statutory law to regulation and fears the consequences of doing so will erode the accountability and transparency to the public in the health system overall. The Bill of Rights is a vital piece of legislation that need not be flexible in regulation, rather must be kept as a reliable tool to protect public interest and ensure that persons receive the care they deserve. There is no draft proposal of the new Bill of Rights at present for public and stakeholder consideration, and in RNAO's view, this legislative home and community care regime is incomplete without it.

15. Strengthen a clear accountability system in home and community care and maintain the minister's oversight over compliance of the *Patients' Bill of Rights* in legislation, with the ability to approve, deny, or terminate home care agencies based on their assessment.

RNAO does not support eliminating the Minister's assessment and the current complaints process as it is in place to protect the rights of persons receiving home and community care services. The current Bill of Rights in the HCCSA includes provisions regarding: respect, abuse, dignity, privacy, autonomy, sensitivity, right to information, consent, and right to be informed about the initiation of complaints. These vital provisions must not be lost and the Minister must continue to oversee that home care agencies comply with the Bill of Rights on an ongoing basis to maintain public safety.

16. Add the same complaints and appeals processes under the existing *Home Care and Community Services Act,* 1994 legislation to the *Connecting Care Act, 2019* and halt plans to shift these processes to regulation.

As written in Schedule 1 of *Bill 175*: A new part V.2 Home and Community Care Complaints and Appeals under the *Connecting Care Act, 2019*.

> *This Part would require a health service provider or Ontario Health Team that provides home and community care services under this Act to establish a process for reviewing complaints in accordance with prescribed requirements. This Part would allow a person to appeal to the Health Services Appeal and Review Board (the "Appeal Board") a prescribed decision of the health service provider or Ontario Health Team concerning a complaint if the prescribed requirements are met.*

In the current HCCSA, the topics of complaints are listed, timelines in which they need to be responded to, and a process for appeals is outlined. It is important that the same complaints and appeals processes under the HCCSA are maintained in legislation under the *Connecting Care Act, 2019* and are not left up to regulation. Home care clients must be protected and should have a clear and legislated complaints and appeals process to follow when they're unable to access care, their needs are not aligned with the care provided to them, they're experiencing inequities based on their region, and if they have had missed visits that compromised their care at any given time. *Bill 175* will not be successful in realizing the broader health system transformation goals to achieve the Quadruple Aim if home and community care clients and their families are not satisfied with their care.

Conclusion

First and foremost, RNAO supports the intent of Bill 175 as a means to fully enable the health transformation agenda and ensure that Ontarians have an integrated balanced health system. Without this type of legislation, the planned integration available through Ontario Health Teams will offer only an imbalanced approach lacking in a robust home and community care sector. If carefully crafted and funded, the *Connecting People to Home and Community Care Act* will mean all Ontarians will be able to receive care where they live, in their homes and the community.

RNAO's ECCO 3.0, designed to maximize and advance the Quadruple Aim of the government's transformation agenda, provides a blueprint for next steps. This legislation will be an important component in realizing health care transformation, if framed to be consistent with the mandate of the OHTs and to ensure a strengthened and enhanced publicly funded home and community care sector and services available to all. The call for this recalibrating all sectors in our health system is now a clarion for change in the context of COVID-19 which exposed the flaws in our imbalanced system of uncoordinated care during COVID-19.

As part of this reform, the Act must ensure that the 4,500 RN care coordinators are immediately transferred as care coordinators to work in primary care and other community sectors. This vital role is an integral part of an effective integrated system. The benefits of integrated care for older persons are comprehensive and include increased quality of life and satisfaction with care, enhanced service coordination, improved health outcomes, reduced duplication of services and a more efficient system.[38]

There is a dire need for reform in the home and community care sector to better meet the goals of quality, continuity of care and care giver, and the range and types of services Ontarians need and deserve. Changes to the service delivery models and requirements for home care agencies to be awarded contracts must acknowledge these types of standards, clearly embodied in RNAO's best practice guidelines and evident in the services provided by those providers who are designated as BPSOs by RNAO.

Finally, if there is truly a commitment to a transformed health system, including a mandate for integration, a balanced system and ability to realize the Quadruple Aim, it is imperative that this Act must include a 20 per cent increase in funding to the home and community care sector, to enable our system to provide publicly funded care to Ontarians where they live, in the home and community.

We must act wisely, to ensure investments result in better care, with better outcomes for the people of Ontario and the staff who supports them, in every corner where they live.

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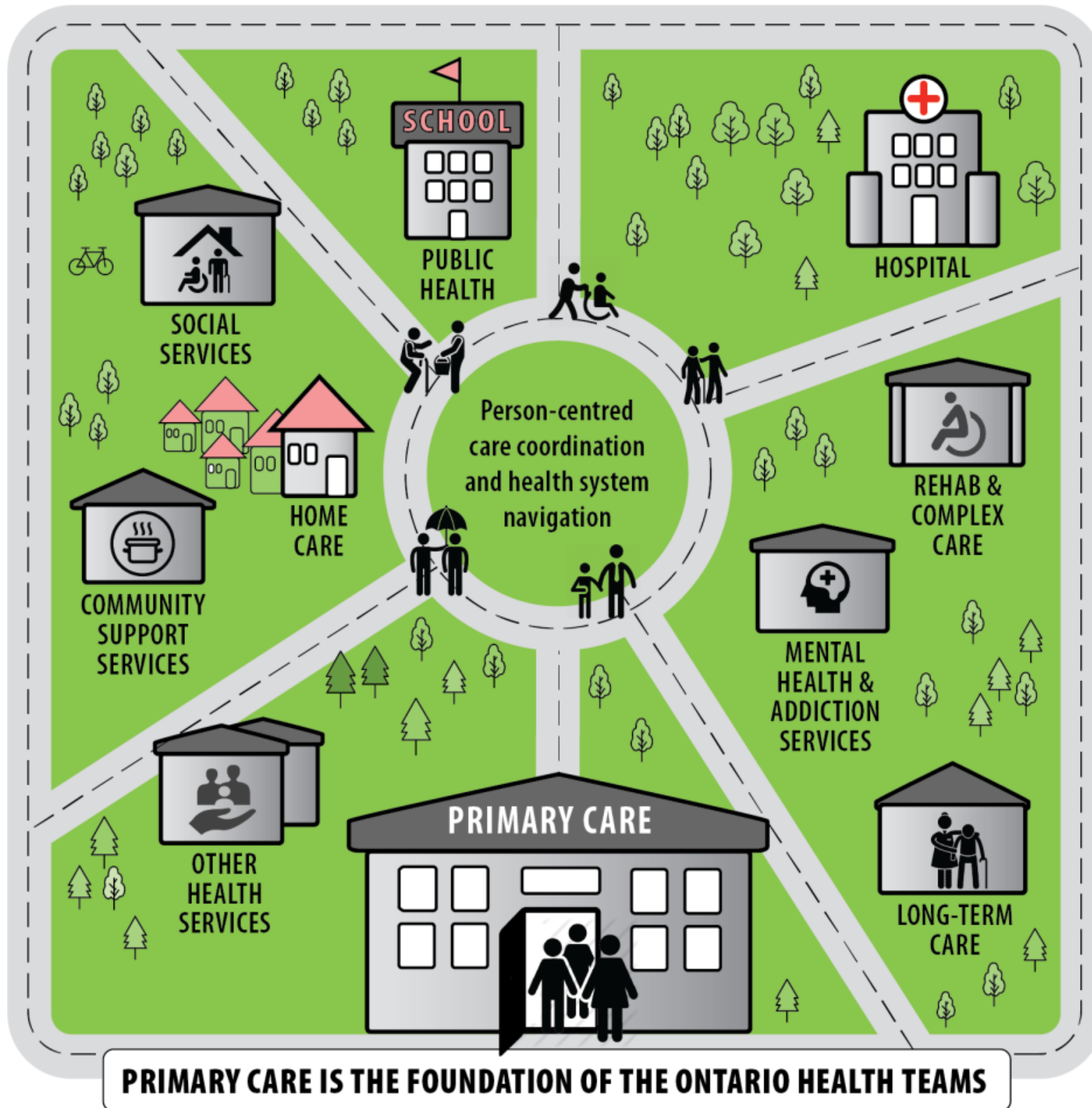
Appendix A: ECCO 3.0 Model



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