RNAO's Response to Bill 74: *The People's Health Care Act*, 2019

Submission to the Standing Committee on Social Policy

April 1, 2019

158 Pearl Street, Toronto, ON M5H1L3 ■ Ph. 416 599 1925 ■ Toll-free 1 800 268 7199 ■ Fax 416 599 1926 ■ RNAO.ca

Summary of RNAO Recommendations:

1. Prohibit Ontario Health (OH) from involvement in direct service delivery and management.

2. Ensure that primary care is the anchor for an integrated health system.

3. Amend Part IV, Integration, 29 (2) (a) to require each Ontario Health Team (OHT) to include primary care as a mandatory service.

4. Amend Part IV, Integration, 29(2) (a) to require each OHT to include home care and mental health and addiction as mandatory services.

5. Enable primary care to lead at a minimum 30 OHTs.

6. Amend Part V, Transfers, 40(2) to move the Primary Care branch currently situated within the MOHLTC to OH.

7. Amend Part V, Transfers, 40(2) to move Public Health Ontario into OH.

8. Immediately transfer the care co-ordination function and the 4,500 RN care co-ordinators working in the LHINs into interprofessional primary care teams, with their salary and benefits intact.

9. Immediately transfer the Mental Health and Addiction Nurses (MHANs) from the LHINs into interprofessional primary care teams and local child and youth mental health (CYMH) agencies, with their salary and benefits intact.

10. Ensure that wait times for children's mental health services are less than 30 days.

11. Immediately transfer the Rapid Response Nurses (RRN) from the LHINs into interprofessional primary care teams, with their salary and benefits intact.

12. Immediately transfer NPs providing integrated palliative care from the LHINs into interprofessional primary care teams, with their salary and benefits intact.

13. Provide hospitals with funding earmarked to immediately post and fill 10,000 RN vacancies.

14. Ensure the implementation of independent RN prescribing in all sectors, inclusive of diagnostic testing by 2019, and integrate RN prescribing into the baccalaureate nursing curriculum by 2020.

15. Ensure regulation is in place by January 2020 authorizing RNs to continue to initiate and perform the controlled act of psychotherapy.

16. Dedicate additional funds to ensure new and existing NPs are compensated fairly and equally across all sectors.

17. Release the funding for the 30 outstanding Attending NP positions in long term care (LTC). And, ensure equity of access to NPs by funding and allocating one NP for 120 residents across all LTC homes in Ontario – to be hired in accordance with the MOHLTC role description and funding policy (full-time position on-site).

18. Remove legislative, regulatory, and practice environment barriers to NP scope of practice, as follows:
    - Authorize NPs to perform point-of-care testing.
    - Authorize NPs to order additional forms of energy (e.g. CT, MRI, nuclear medicine procedures, non-invasive EEGs, and ECGs in all situations).
    - Authorize NPs to apply specified forms of energy (e.g. defibrillation).
    - Expand NPs' authority to certify a death.
    - Authorize NPs to complete Forms 1, 2, 3, 4, 5, 14, and 28 for mental health services.
    - Ensure NPs are enabled to act as most responsible providers in hospital.

19. Add to the preamble:

    The people of Ontario and their government:

    Believe that everyone living in Ontario should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.

    Acknowledge that health promotion and prevention are key to sustainable health systems.

20. Add to Part 1.1, Interpretation:

    Health is the highest attainable state of physical, mental and social well-being, including the ability to adapt and self-manage in the face of social, physical, and emotional challenge; it is not merely the absence of disease or infirmity;

    Health promotion is the process of enabling people to increase control over, and to improve, their health.

    Specific outcomes for diverse communities is the avoidable, unfair, or remediable differences in health outcomes and health access among individuals or groups of people, whether they are

defined socially, economically, demographically or geographically or by other means of stratification.

21. Add to Part 2.6, Objects of the Agency:

(b) (ix) the development and implementation of strategies and accountability and reporting mechanisms for health promotion and prevention;

(b) (x) the development and implementation of strategies and accountability and reporting mechanisms to reduce the avoidable and remediable differences in health outcomes and health access between groups of people in Ontario;

(h) to respect the diversity of communities, including but not limited to Indigenous and Francophone populations, in the planning, design, delivery and evaluation of services;

22. Add to Part VII, Regulations:

Section 48 (g) requiring a health service provider, integrated care delivery system, or other person or entity that receives funding from the Agenda under section 21 to institute a system for collecting socio-demographic and race-based data in order to be able to report on progress toward specific outcomes for the diverse communities in Ontario.

Section 48 (h) requiring a health service provider, integrated care delivery system, or other person or entity that receives funding from the Agenda under section 21 to institute an accountability and quality improvement plan for health promotion and the prevention of chronic disease and injury.

23. Require not-for-profit entities to be the foundation of the People's Health Care Act, 2019

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 appreciates the opportunity to provide feedback to the Standing Committee on Social Policy on Bill 74, *An Act concerning the provision of health care, continuing Ontario Health and making consequential and related amendments and repeals*, known in its short title as, *The People's Health Care Act, 2019.*

Each day across the province, many Ontarians receive life-saving and wellness-enhancing health services thanks to Canada's Medicare – a universal, single-payer health insurance system cherished by its citizenry. The support and care of a person's chosen family aligned with the knowledge, skill, and judgment of dedicated health professionals has allowed many Ontarians to have a high-quality life and a peaceful death. While acknowledging these strengths, there is much left to do. For many years RNAO has been urging the provincial government to recalibrate the balance between life-saving and wellness-enhancing services (strengthening the later), and address flaws that result in barriers to access with inequitable health outcomes, hallway health care, and other detrimental experiences.

RNAO supports a health system transformation that will enable a person-centred, seamless health system that will promote health, prevent disease, and provide personalized wrap-around services to manage acute, chronic, and palliative care needs. In order to realize this objective, RNAO is pleased to offer the following pragmatic, solution-focused recommendations:

Structural changes and clinical service improvements: Both necessary

As RNAO has argued with respect to the Local Health Integration Networks (LHIN),[1] the roles of providing oversight of a health system and providing direct services must be separate. To avoid the challenges of trying to steer and row at the same time, it is important to ensure that Ontario Health (OH) provides planning, funding, and accountability, while the Ontario Health Teams (OHTs) provide direct service delivery and its management. While structural changes to enable the formation of OH is important, changes to facilitate the formation and optimal functioning of OHTs are even more critical. Structural changes without support for clinical service improvements will not result in better health services and experiences for Ontarians, nor will it deliver better health outcomes and health system efficiencies.

Recommendation 1: Prohibit Ontario Health (OH) from involvement in direct service delivery and management.

RNAO's Submission on Bill 74: *The People's Health Care Act*, 2019.

Make primary care the anchor of an integrated health system

As we stated in the introduction to this submission, RNAO has insisted for many years the need for government to urgently recalibrate the balance between life-saving and wellness-enhancing services (strengthening the latter).

By anchoring Ontario's health system in primary care as the best health care systems do globally, quality of care, health outcomes, and cost savings will be improved. Informed by the evidence gathered in RNAO's foundational reports, *Enhancing Community Care for Ontarians (ECCO)*[2] and *Primary Solutions for Primary Care*,[3] it is imperative that primary care anchor the proposed integrated health system.

Primary care provides person and family-centred care that is comprehensive and continuous from before birth to death. While undoubtedly other health services that could make up OHTs provide critical functions (hospitals, rehabilitation, home care or community services, palliative care, long-term care, and mental health and addiction services), it is primary care that provides continuity of care over a lifetime. Amendments must be made to this draft legislation to require each OHT to include primary care as a mandatory service. To reflect the strong capacity that is already available in the primary care sector, RNAO recommends – in the strongest possible terms – that primary care be the lead organization in a minimum 30 OHTs. Many Community Health Centres (CHC), Aboriginal Health Access Centres (AHACs), Nurse Practitioner-Led Clinics (NPLCs) and Family Health Teams (FHTs), are ready and eager to take on this leadership role. To keep people out of hospital and to support them upon discharge, community care (home care and mental health and addiction services) should also be mandatory for each OHT.

Recommendation 2: Ensure that primary care is the anchor for an integrated health system.

Recommendation 3: Amend Part IV, Integration, 29 (2) (a) to require each Ontario Health Team (OHT) to include primary care as a mandatory service.

Recommendation 4: Amend Part IV, Integration, 29(2) (a) to require each OHT to include home care and mental health and addiction as mandatory services.

Recommendation 5: Enable primary care to lead at a minimum 30 OHTs.

Appropriate structural changes and transition of resources from the LHINs to OH and OHTs

Important structural changes will be needed in order to make primary care the anchor of an integrated health system. It would be appropriate, for example, to move the Primary Care branch currently situated within the

MOHLTC to OH. It would also make sense to integrate Public Health Ontario into OH as it fits with the objects of the Agency. Mechanisms to facilitate mandatory linkages and active participation between public health units (PHUs) and OHTs must be found. This would support clinicians in their practice and help inform population health needs and programs with data and community consultations.

To support integrated health services and further strengthen the capacity of primary care, RNAO is urging the immediate transfer of the 4,500 RN care co-ordinators working in LHINs and the care co-ordinator function to primary care. This can be done now without waiting for the formation of OHTs. Again, many CHC, AHACs, NPLCs and FHTs, are ready and eager to have RN care co-ordinators as integral team members. Having 4,500 RN care co-ordinators in interprofessional primary care teams will usher in a new experience for Ontarians, as they are supported in an upstream way to co-ordinate their needs and to help them navigate the complexities of the health system maze. We want to emphasize that labour agreements ought not to be disrupted to successfully achieve this transition. This transition should result in a substantive strengthening of primary care that is cost-neutral as people move with their compensation intact.

Emergency room visits by children and youth experiencing a mental health issue increased by 72 per cent, and hospitalizations have risen by 79 per cent over the last decade. Although these issues can be life-threatening, many children and youth are waiting up to two years to access mental health services. Children's Mental Health Ontario (CHMO) and RNAO have partnered together to offer two recommendations to the government that will support connected care and make a real difference for Ontario children and families (Appendix 1). We recommend immediately shifting the Mental Health and Addiction Nurses (MHAN) from LHINs into interprofessional primary care teams and local child and youth mental (CYMH) agencies. By transferring the MHANs, and the attached funding, from the LHINs into local interprofessional primary care teams and CYMH agencies, where they will continue to work directly out of schools on a day-to-day basis, there will be better collaboration between schools and community providers to address the diverse needs of students. As with the 4,500 RN care co-ordinators, this change too can be implemented immediately. Another recommendation is to hire front-line professionals to ensure children and families can get the help they need in 30 days or less. Implementing both of these recommendations will ease suffering. And, according to CMHO calculations, it also has the potential to save the province $220 million per year, spent in hospitals to address issues that can be avoided.

Other transformative nursing roles that must be transferred from LHINs to OHTs include rapid response nurses (RRNs) and NPs providing integrated palliative care. RRNs provide intensive in-home services to people with complex care needs. NPs in the integrated palliative care program provide direct care to complex palliative patients. In both roles, these specialized RNs and NPs serve as supports for families and caregivers as well as resources for other members of the health team. As with the RN care-coordinators and MHANs, RRNS and NPs providing integrated palliative care should be relocated now in a planned fashion into interprofessional primary care teams, with their salaries and benefits intact. As RNAO has written to Deputy Minister, Helen Angus, this

will help avoid confusion, multiple transitions, and possible attrition of nursing expertise likely to happen in a scenario where RNs and NPs go first to OH while awaiting the formation of OHTs. (Appendix 2)

Recommendation 6: Amend Part V, Transfers, 40(2) to move the Primary Care branch currently situated within the MOHLTC to OH.

Recommendation 7: Amend Part V, Transfers, 40(2) to move Public Health Ontario into OH.

Recommendation 8: Immediately transfer the care co-ordination function and the 4,5000 RN care co-ordinators working in the LHINs into interprofessional primary care teams, with their salary and benefits intact.

Recommendation 9: Immediately transfer the Mental Health and Addiction Nurses (MHAN) from the LHINs into interprofessional primary care teams and local child and youth mental health (CYMH) agencies, with their salary and benefits intact.

Recommendation 10: Ensure that wait times for children's mental health services are less than 30 days.

Recommendation 11: Immediately transfer the Rapid Response Nurses (RRNs) from the LHINs into interprofessional primary care teams, with their salary and benefits intact.

Recommendation 12: Immediately transfer NPs providing integrated palliative care from the LHINs into interprofessional primary care teams, with their salary and benefits intact.

Full utilization of RNs and NPs ensuring full scope of practice utilization and adequate investments

MPPs that have been visited by RNAO members in their ridings or at Queen's Park are well aware of the evidence that RNs and NPs increase access and improve clinical, organizational, and financial outcomes in our health system.[4] [5] For the third year in a row, Ontario has the lowest RN-to-population ratio in Canada.[6] In order to improve the health of Ontarians and the quality, efficiency, and effectiveness of the health system, it is essential that key investments be made in the nursing workforce. Health systems work better when all of their regulated health professionals are enabled to work to their full scope of practice. In 2018, the job count for nurses working already in primary care was 10,584. Of these, RNs: 4,506; NPs: 1,729; and RPNs: 4,349.[7] Just imagine how these 10,584 RN, NPs and RPNs, working to their full scope, side by side with MHANs, RRNs, NP integrated palliative care providers, and the 4,500 RN care co-ordinators transferred from the LHINs to primary care could strengthen this sector overnight and how this will positively impact every single Ontarians in every corner of our awesome province. It will ensure same day or next day access, improve clinical services, enrich health promotion and disease prevention, help people navigate the system, and address upstream

challenges that many Ontarians face day in and day out, such as social isolation of seniors (by offering group activities), income insecurity and housing.

Without repeating the evidence, RNAO reiterates the following recommendations from our 2019 Queen's Park backgrounders on RNs[8] and NPs[9]:

Recommendation 13: Provide hospitals with funding earmarked to immediately post and fill 10,000 RN vacancies.

Recommendation 14: Ensure the implementation of independent RN prescribing in all sectors, inclusive of diagnostic testing by 2019, and integrate RN prescribing into the baccalaureate nursing curriculum by 2020.

Recommendation 15: Ensure regulation is in place by January 2020 authorizing RNs to continue to initiate and perform the controlled act of psychotherapy.

Recommendation 16: Dedicate additional funds to ensure new and existing NPs are compensated fairly and equally across all sectors.

Recommendation 17: Release the funding for the 30 outstanding Attending NP positions in long-term care (LTC). And, ensure equity of access to NPs by funding and allocating one NP for 120 residents across all LTC homes in Ontario – to be hired in accordance with the MOHLTC role description and funding policy (full-time position on-site).

Recommendation 18: Remove legislative, regulatory, and practice environment barriers to NP scope of practice, as follows:

- Authorize NPs to perform point-of-care testing.
- Authorize NPs to order additional forms of energy (e.g. CT, MRI, nuclear medicine procedures, non-invasive EEGs, and ECGs in all situations).
- Authorize NPs to apply specified forms of energy (e.g. defibrillation).
- Expand NPs' authority to certify a death.
- Authorize NPs to complete Forms 1, 2, 3, 4, 5, 14, and 28 for mental health services.
- Ensure NPs are enabled to act as most responsible providers in hospital.

Building a more equitable health system

The values of RNAO include respect for human dignity and a commitment to diversity, inclusivity, equity, social justice, and democracy. Arising from those values, RNAO seeks to "influence healthy public policy to

RNAO's Submission on Bill 74: *The People's Health Care Act*, 2019.

positively impact the determinants of health, supporting Medicare and strengthening a publicly funded, not-for-profit health-care system."[10] The evidence is clear that some groups and communities experience worse health outcomes, including premature death, and increased difficulty accessing services. In order to improve the health of all Ontarians and decrease health inequities, RNAO supports the Alliance for Healthier Communities and the Ontario Public Health Association's proposed amendments listed below related to the preamble, interpretation, objects of the Agency, and regulations.[11]

Recommendation 19: Add to the preamble:

The people of Ontario and their government:

Believe that everyone living in Ontario should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.

Acknowledge that health promotion and prevention are key to sustainable health systems.

Recommendation 20: Add to Part 1.1, Interpretation:

Health is the highest attainable state of physical, mental and social well-being, including the ability to adapt and self-manage in the face of social, physical, and emotional challenge; it is not merely the absence of disease or infirmity;

Health promotion is the process of enabling people to increase control over, and to improve, their health.

Specific outcomes for diverse communities is the avoidable, unfair, or remediable differences in health outcomes and health access among individuals or groups of people, whether they are defined socially, economically, demographically or geographically or by other means of stratification.

Recommendation 21: Add to Part 2.6, Objects of the Agency:

(b) (ix) the development and implementation of strategies and accountability and reporting mechanisms for health promotion and prevention;

(b) (x) the development and implementation of strategies and accountability and reporting mechanisms to reduce the avoidable and remediable differences in health outcomes and health access between groups of people in Ontario;

(h) to respect the diversity of communities, including but not limited to Indigenous and Francophone populations, in the planning, design, delivery and evaluation of services;

Recommendation 22: Add to Part VII, Regulations:

> Section 48 (g) requiring a health service provider, integrated care delivery system, or other person or entity that receives funding from the Agenda under section 21 to institute a system for collecting socio-demographic and race-based data in order to be able to report on progress toward specific outcomes for the diverse communities in Ontario.
>
> Section 48 (h) requiring a health service provider, integrated care delivery system, or other person or entity that receives funding from the Agenda under section 21 to institute an accountability and quality improvement plan for health promotion and the prevention of chronic disease and injury.

Safeguarding sustainability

There is evidence that mortality rates were higher in for-profit hospitals[12] and hemodialysis facilities[13] compared with their not-for-profit counterparts. Even so, for-profit hospitals resulted in higher costs for care than not-for profits hospitals.[14] For-profit home health agencies in the United States scored lower in clinically important outcomes such as avoidance of hospitalization while costing more due to profit and higher administrative costs compared with not-for-profit agencies.[15] A more recent analysis found that caesarean sections were more likely to be performed by for-profit hospitals compared with not-for-profit hospitals regardless of women's risk and contextual factors such country, year, or study design.[16] At the systems level, Canada's closest neighbour, the United States, has for-profit health care as a key structural element. In 2017, the result is the most expensive health care system in the world at 17.1 per cent of GDP (10,209 USD per capita).[17] For the same year, Canada's health spending was 10.4 per cent of GDP (4,826 USD per capita).[18] In 2017, 8.8 per cent of the American population, or 28.5 million people, did not have any health insurance at any point during that year.[19] More spending did not equate to better health outcomes with the United States having higher infant mortality rates[20] and lower life expectancy at birth[21] compared with Canada.

At the individual and family level, RNAO appreciates the prohibition that "no integration decision shall permit a transfer of services that results in a requirement for an individual to pay for those services, except as otherwise by law."[22] At the systems level, RNAO urges the government to safeguard the sustainability and quality of the health care system by requiring not-for-profit entities to be the foundation of this transformation process. Being agnostic about whether the provision of health services is for-profit or not-for-profit will create conditions sure to increase costs while exacerbating two-tiered health care. At the very least, the government must prohibit the introduction of any additional for-profit health services.

Recommendation 23: Require not-for-profit entities to be the foundation of the *People's Health Care Act*, 2019.

Conclusion

As health-care professionals, citizens, tax-payers, current or future patients, and human beings concerned about our loved ones, Ontario's nurses are strongly invested in our health system. As such, we urge you to move a person-centred, seamless health system from an aspiration to a reality.

Thank you to the Standing Committee on Social Policy for considering these recommendations.

References

[1] Registered Nurses' Association of Ontario (2016, Nov. 23). *RNAO's Response to Bill 41: Patients First Act, 2016*. Submission to the Standing Committee on Legislative Assembly, 8. https://rnao.ca/sites/rnao-ca/files/RNAO_FINAL_Response_to_Bill_41_-_Nov_23_2016_v2.pdf

[2] Registered Nurses' Association of Ontario (2014, April). *Enhancing Community Care for Ontarians (ECCO) 2.0: Three Year Plan.* Toronto: Author. https://rnao.ca/sites/rnao-ca/files/RNAO_ECCO_2_0.pdf

[3] Registered Nurses' Association of Ontario (2012, June).*Primary Solutions for Primary Care: Maximizing and Expanding the Role of the Primary Care Nurse in Ontario*. https://rnao.ca/policy/reports/primary-solutions-primary-care

[4] Registered Nurses' Association of Ontario (2019). Backgrounder: Increase access to care by fully utilizing NPs. https://rnao.ca/sites/rnao-ca/files/Increase_access_to_care_by_fully_utilizing_NPs_QPD_2019_Final_Public.pdf

[5] Registered Nurses' Association of Ontario (2019). Backgrounder: Reclaiming the role of the RN. https://rnao.ca/sites/rnao-ca/files/Reclaiming_the_role_of_the_RN_QPD_2019_Final_Public_0.pdf

[6] Registered Nurses' Association of Ontario (2018). Media release: Ontario has the worst RN-to-population ratio in Canada: Province must hire more RNs to end hallway nursing. https://rnao.ca/news/media-releases/2018/06/14/ontario-has-worst-rn-population-ratio-canada-province-must-hire-more-

[7] College of Nurses of Ontario (2019). Data Query Tool. "Parts of this material are based on data provided by the College of Nurses of Ontario. However, the analyses and opinions expressed here are those of the authors, and not necessarily those of the College." http://www.cno.org/en/what-is-cno/nursing-demographics/data-query-tool/

[8] Registered Nurses' Association of Ontario (2019). Backgrounder: Reclaiming the role of the RN. https://rnao.ca/sites/rnao-ca/files/Reclaiming_the_role_of_the_RN_QPD_2019_Final_Public_0.pdf

[9] Registered Nurses' Association of Ontario (2019). Backgrounder: Increase access to care by fully utilizing NPs. https://rnao.ca/sites/rnao-ca/files/Increase_access_to_care_by_fully_utilizing_NPs_QPD_2019_Final_Public.pdf

[10] Registered Nurses' Association of Ontario. Mission and values. https://rnao.ca/about/mission

[11] Alliance for Healthier Communities and the Ontario Public Health Association (2019, March 6). Letter to Minister Elliott on *People's Health Care Act*, 2019https://opha.on.ca/getattachment/dd486320-a89b-420c-a894-4e6ed4d905af/Health-Minister-Letter-Bill-74-Amendments-Alliance-OPHA-Mar-6-2019.pdf.aspx?ext=.pdf

[12] Devereaux, P., Choi, P., Lacchetti, C., Weaver, B. et al. (2002). A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. *Canadian Medical Association Journal*. 166(11): 1399-1406.

[13] Devereaux, P., Schunemann, H., Ravindran, N., Bhandari, M. et al. (2004). Comparison of mortality between private for-profit and private not-for-profit hemodialysis centers: A systematic review and meta-analysis. *Journal of the American Medical Association*. 288(19): 2449-2457.

[14] Devereaux, P., Heels-Ansdell, D., Lacchetti, C., Haines, T. et al. (2004). Payments for care at private for-profit and private not-for-profit hospitals: A systematic review and meta-analysis. *Canadian Medical Association Journal*. 170(12): 1817-1824.

[15] Cabin, W., Himmelstein, D., Siman, M., & Woolhandler (2014, August). For-profit medicare home health agencies' costs appear higher and quality appears lower compared to nonprofit agencies. *Health Affairs*. 33(8): 1460-1465.

[16] Hoxha, I, Syrogiannouli, L, Luta, X., Tak, K. et al. (2017). Caesarean sections and for-profit status of hospitals: Systematic review and meta-analysis. *BMJ Open*. 7(2): e13670.

[17] OECD, Health spending chart. Health expenditure indicators. https://data.oecd.org/healthres/health-spending.htm

[18] OECD, Health spending chart. Health expenditure indicators. https://data.oecd.org/healthres/health-spending.htm

[19] Berchick,E., Hood, E., Barnett, J. (2018, September). *Health insurance coverage in the United States: 2017*. Washington, DC: United States Census Bureau, 1.. https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf

[20] The infant mortality rate (per 1,000 live births) in 2017 was 4.5 for Canada compared with 5.7 for the United States. World Bank. World Development Indicators. https://databank.worldbank.org/data/reports.aspx?source=2&series=SP.DYN.IMRT.IN&country=

[21] The life expectancy at birth in 2016 was 82.3 years in Canada compared with 78.7 years in the United States. World Bank. World Development Indicators. https://databank.worldbank.org/data/reports.aspx?source=2&series=SP.DYN.LE00.IN&country=

[22] Bill 74, *People's Health Care Act*, 2019, Part IV, Integration, 34 (1), 17.

APPENDIX 1

The Honourable Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care
College Park, 5th Floor
777 Bay Street
Toronto, Ontario M7A 2J3

March 20, 2019

Dear Minister Elliott,

Re: Child & Youth Mental Health

Last month, the Ministry of Health and Long-Term Care announced plans for two significant change initiatives: the formation of Ontario Health and the establishment of Ontario Health Teams. Combined with significant investments in mental health and addiction services, these changes have the potential to vastly improve how our health-care system is administered and how Ontarians experience the health-care system.

The Registered Nurses' Association of Ontario (RNAO) passed a resolution (see attached) recognizing that child and youth mental health is a key issue for nurses. RNAO is partnering with Children's Mental Health Ontario (CMHO) to develop recommendations to government that will support connected care and make a real difference for Ontario children and families. To-date, we have two key recommendations that are time-sensitive:

1) **We recommend immediately shifting the Mental Health and Addictions Nurses (MHANs) from the LHINs into interprofessional primary care teams and local child and youth mental health (CYMH) agencies.**

2) **We recommend the government ensure that wait times for children's mental health services are less than 30 days to stop the skyrocketing hospitalization rates for children and youth.**

Christine, we would like to meet with you urgently to discuss these important and time-sensitive recommendations.

APPENDIX 1

Recommendation 1: Transferring and Better Connecting Mental Health and Addictions Nurses (MHANs)

In anticipation of the introduction of Ontario Health and Ontario Health Teams, there is an opportunity to shift the MHANs from the LHINs to interprofessional primary care teams and to child and youth mental health agencies. This small but significant change, implemented at no additional cost to the government, will better connect and integrate services for children, youth, and families struggling with mental health issues.

Announced in 2012, 144 Mental Health and Addictions Nurses (MHANs) were hired to work in elementary and secondary schools to provide early identification and intervention supports and services. These nurses focus on helping students with mental health and addiction issues thrive at school, remain in school or successfully transition back to school after receiving specialized mental health and addictions services in hospital or community.

RNAO trained at the time these RNs, and no doubt MHANs play a critical role, in promoting the health, well-being, and success of young people in schools—and they have performed admirably in their roles. However, as RNAO insisted at the time, housing MHANs in CCACs and then LHINs has created barriers to the coordination and connection of care for children and their families. MHANs are currently employees of the LHINs that work in schools, and as a result, in some communities, there is very little connection between the MHANs and primary care teams or CYMH agencies. For kids with more significant mental health issues who require more support than can or should be provided within the walls of a school, this creates additional complexities and barriers to accessing treatment.

As the province moves forward with its plan for a more comprehensive and connected health-care system, CMHO and RNAO recommend that the MHANs, and the attached funding, be transferred from the LHINs into local interprofessional primary care teams and CYMH agencies, where they will continue to work directly out of schools on a day-to-day basis. Interprofessional primary care teams and CYMH agencies have the ability to appropriately supervise and manage MHANs and would be excited to be able to work directly with them.

This shift will ensure that the appropriate connections are made between schools and community providers, for those young people who need more support than can or should be provided in school. This will immensely improve collaboration between schools and community providers, in meeting the needs of young people with a range of mental health issues, across the continuum of care. Minister, we very strongly believe that there is no need or reason to wait to make this change and are asking for your immediate action on it.

APPENDIX 1

Recommendation 2: Reducing Wait Times From Up to 24 Months to 30 Days or Less

Of course, long wait times and gaps in capacity in child and youth mental health treatment will continue to be a barrier to access without additional investments. Changes to improve the coordination of care, such as moving MHANs to interprofessional primary care teams and CYMH agencies, must be accompanied by substantial investments to hire more front-line professionals to ensure children and their families can get the help they need – in a timely manner -- where they need it.

The recently signed bilateral Health Transfer agreement articulated the reduction of wait times in children's mental health as the top priority. The federal government investment plus the Ontario governments' matching amounts to $200M are available to reduce wait times right now. Mental health is a life-threatening issue – children can die if they wait and some do die – bringing tragedy upon themselves, their loved ones and our communities. It is a crisis that nurses and families are seeing first hand every day. And while we understand that the government is facing significant financial pressures, we must remind you that investing in community-based services will ameliorate suffering and bring savings in reduced hospitalizations. We estimate that 1,400 clinicians, including registered nurses, are needed all over the province to attend to children's mental health. Over the past decade, emergency department visits by children and youth experiencing a mental health issue have risen by 72%, and hospitalizations by 79%. CMHO has estimated that each year the province spends $220M in hospitals that can be avoided. That's a potential saving of $1 billion over five years.

Christine, we are eager to meet with you to move these two priorities ahead. We will follow up to coordinate a meeting.

With warmest regards and thanks,

Doris Grinspun, RN, MSN, PhD, LLD(hon), Dr (hc), FAAN, O.ONT
CEO, Registered Nurses' Association of Ontario

Kimberly Moran, CPA, CA

APPENDIX 1

CEO, Children's Mental Health Ontario

cc. Helen Angus, Deputy Minister, Health and Long-Term Care
Larissa Smit, Senior Policy Advisor, Office of the Premier of Ontario
Heather Watt, Chief of Staff, Office of the Minister of Health and Long-Term Care
Charles Lammam, Director of Policy, Office of the Minister of Health and Long-Term Care
Laurel Brazill, Director of Stakeholder Relations, Office of the Minister of Health and Long-Term Care

APPENDIX 2

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

Helen Angus
Deputy Minister
Ministry of Health and Long-Term Care
College Park, 5th Floor
777 Bay Street
Toronto, ON M7A 2J3

April 1, 2019

Re: Transition of Nursing Human Resources from the LHINs to Enhancing Community Care for Ontarians (ECCO) model: Updated transitional structure

Dear Helen,

The Registered Nurses' Association of Ontario (RNAO) welcomed Minister Elliott's February 26, 2019 announcement of health-care reform designed to address flaws that harm Ontarians such as hallway health care and health services that operate in silos.[1] In order to further the government's objective of building a person-centred, seamless health system, RNAO urges you to fully consider all the elements of RNAO's *Enhancing Community Care for Ontarians* (ECCO) model.[2] By anchoring Ontario's health system in primary care as the best health care systems do globally, quality of care, health outcomes, and cost savings will be improved.

Helen, RNAO is urging you to not make the same mistakes that were done when CCACs were eliminated. At the time, RNAO argued that the Local Health Integration Networks' (LHINs')[3] roles of providing oversight of a health system and providing direct services must be separate. To avoid the challenges of trying to steer and row at the same time, it is important to ensure that Ontario Health (OH) provides planning, funding, and accountability and the Ontario Health Teams (OHTs) provide direct service delivery and its management.

In addition, we want to emphasize that while structural changes to enable the formation of OH are important, changes to facilitate the formation and optimal functioning of OHTs are even more critical. Structural changes without support for clinical service improvements will not result in better health services and experiences for Ontarians, nor will it deliver better health outcomes and health system efficiencies.

RNAO urges you and your team to immediately begin the transition of nursing human resources from the LHINs directly into interprofessional primary care teams. There is no need to move these vital resources to the OH agency and/or wait until OHTs are formed. Transitioning expert RNs and NPs to primary care will immediately strengthen this vital sector while avoiding confusion and multiple transitions.

RNAO is urging the immediate transfer of the 4,500 RN care co-ordinators working in LHINs and the care co-ordinator function to primary care. Many Community Health Centres (CHC), Aboriginal Health Access Centres (AHACs), Nurse Practitioner-Led Clinics (NPLCs) and Family Health Teams (FHTs), are ready and eager to have RN care co-ordinators as an integral team member. Having 4,500 RN care co-ordinators in interprofessional primary care teams will usher in a new experience for Ontarians, as they are supported in an upstream way to coordinate their needs and to help them navigate the complexities of the health system maze. We want to emphasize that labour agreements ought not to be disrupted to successfully achieve this transition. This transition should result in a substantive strengthening of primary care that is cost-neutral as people move with their compensation intact.

Over the last decade, emergency room visits by children and youth experiencing a mental health issue increased by 72 per cent, and hospitalizations have risen by 79 per cent. Although these issues can be life-threatening, many children and youth are waiting up to two years to access mental health services. Children's Mental Health Ontario (CHMO) and RNAO have partnered to offer two recommendations to the government that will support connected care and make a real difference for Ontario children and families. We recommend immediately shifting the Mental Health and Addiction Nurses (MHAN) from LHINs into interprofessional primary care teams and local child and youth mental (CYMH) agencies. By transferring the MHANs, and the attached funding, from the LHINs into local interprofessional primary care teams and CYMH agencies, where they will continue to work directly out of schools on a day-to-day basis, there will be better collaboration between schools and community providers to address the diverse needs of students. As with the 4,500 RN care co-ordinators, this change too can be implemented immediately. The second recommendation is to hire front-line professionals to ensure children and families can get the help they need in 30 days or less. Implementing both of these recommendations will ease suffering. And, according to CMHO calculations, it also has the potential to save the province $220 million per year, spent in hospitals to address issues that can be avoided.

Other transformative nursing roles that must be transferred from LHINs to OHTs include rapid response nurses (RRNs) and NPs providing integrated palliative care. RRNs provide intensive in-home services to people with complex care needs. NPs in the integrated palliative care program provide direct care to complex palliative patients. In both roles, these specialized RNs and NPs serve as supports for families and caregivers as well as resources for other members of the health team. As with the RN care-coordinators and MHANs, RRNs and NPs providing integrated palliative care should be relocated now in a planned fashion into interprofessional primary care teams, with their salaries and benefits intact.

Helen, RNAO is eager to work with you and your team to ensure all nursing human resources currently located in the LHINs do not disappear, but rather are relocated in a planned fashion to

primary care – beginning now and not waiting until OHTs are formed. RNAO recommends that a transition plan be generated, communicated, and implemented immediately.

RNAO continues to stand ready to assist the Ministry in improving access, equity, and the quality of health and nursing services for Ontarians. Thank you for considering this feedback.

Warm regards,

Doris Grinspun, RN, MSN, PhD, LLD(hon), Dr(hc), FAAN, O.ONT
Chief Executive Officer, RNAO

CC: Hon. Christine Elliott, Minister of Health and Long-Term Care
Dr. Rueben Devlin, Special Advisor Healthcare, Chair *Premier's Council on Improving Healthcare & Ending Hallway Medicine*

[1] Registered Nurses' Association of Ontario (2019, Feb. 26). Media release: Nurses welcome health system reform and urge the government to ensure RNs and NPs play key role. https://rnao.ca/news/media-releases/2019/02/26/nurses-welcome-health-system-reform-and-urge-government-ensure-rns-an

[2] Registered Nurses' Association of Ontario (2014, April). Enhancing Community Care for Ontarians (ECCO) 2.0: Three Year Plan. Toronto: Author. https://rnao.ca/sites/rnao-ca/files/RNAO_ECCO_2_0.pdf

[3] Registered Nurses' Association of Ontario (2016, Nov. 23). *RNAO's Response to Bill 41: Patients First Act, 2016*. Submission to the Standing Committee on Legislative Assembly, 8. https://rnao.ca/sites/rnao-ca/files/RNAO_FINAL_Response_to_Bill_41_-_Nov_23_2016_v2.pdf