# ECCO

# ENHANCING COMMUNITY CARE FOR ONTARIANS

RNAO - ECCO MODEL 3.0

**MAY 2020**

RNAO
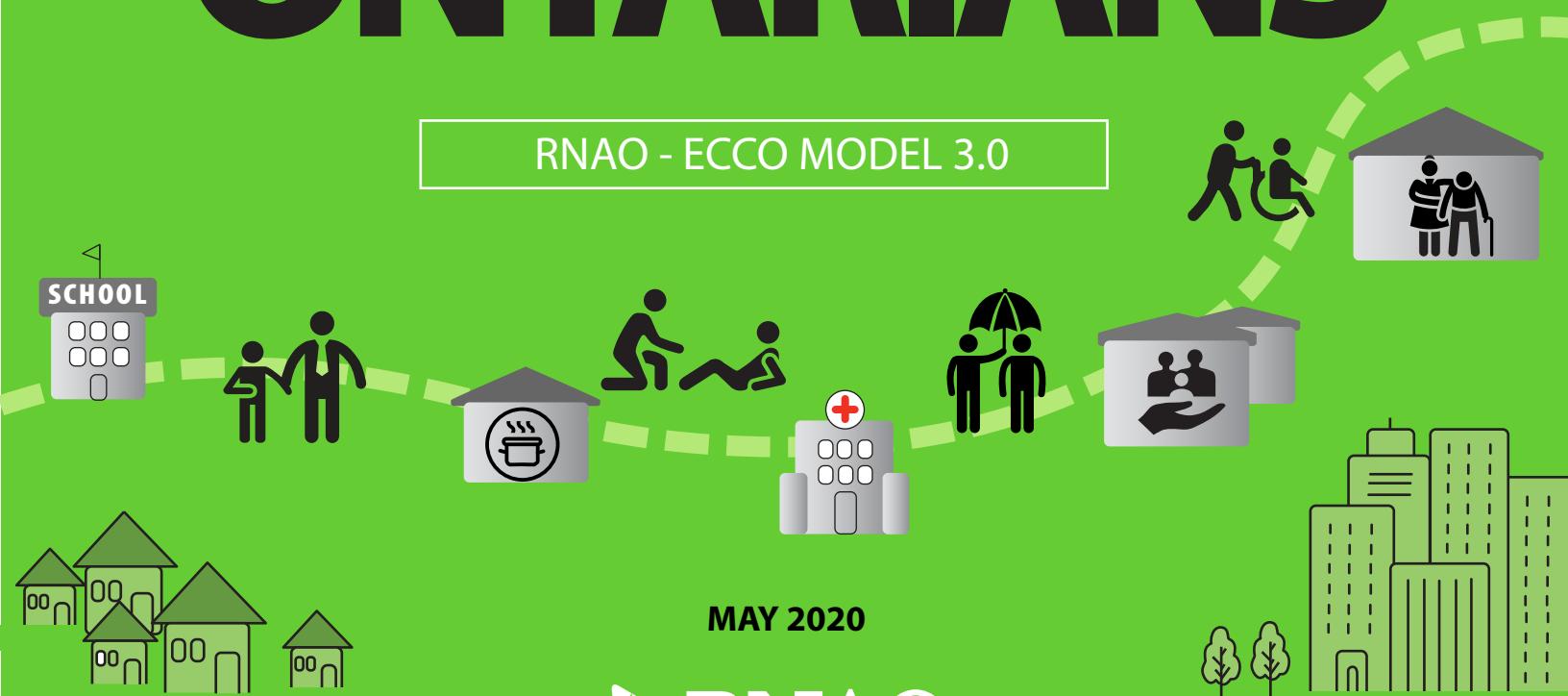
In 1867, Florence Nightingale wrote:

**"My view you know is that the ultimate destination is the nursing of the sick in their own homes. … I look to the abolition of all hospitals and workhouse infirmaries. But it is no use to talk about the year 2000."[1]**
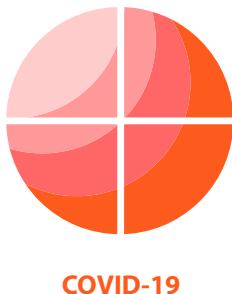
THE YEAR OF
**THE NURSE**
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**KNOWLEDGE**
**COMPASSION**
**COURAGE**

COVID-19

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*Enhancing Community Care for Ontarians (ECCO)* 3.0 was first intended as a call, in the context of Ontario's health-system transformation, to both government and health-system partners to strengthen community care and anchor the health system in primary care to better meet the needs of all residents. Over the period of its development, ECCO 3.0 has become an urgent response to the need for an integrated health system that can effectively serve Ontarians at all times, even when confronted with a deadly pandemic – COVID-19 – that has ravaged the lives of Ontarians and their communities.

Ontario's health-system transformation, including the launch of Ontario Health and its now existing 24 Ontario Health Teams (OHT), has been put to the test ahead of schedule. Our response to COVID-19 highlights the work needed ahead to make a marked difference for the people of Ontario, through an integrated system of care. Evidence shows that for the first four months of the COVID-19 pandemic, Ontario's response was focused mainly on the role of hospitals. All other sectors were an afterthought. This reality must change if we are to fully realize the power of OHTs.

As health officials have pointed out, COVID-19 in Ontario is a tale of two pandemics. One is the management of the spread of the disease in the general population, and its containment though physical distancing, self-isolation and hospitalization, when necessary. Public health officials cautiously shared on April 20, 2020, that community spread had peaked and we were heading down the curve. The second tale of COVID-19 in Ontario is the growing spread in congregate settings – all related to vulnerable populations. RNAO has decried on numerous occasions throughout this pandemic the lack of timely public health action in congregate settings overall, and specifically the devastating effect of COVID-19 on residents of long-term care and retirement homes. On March 2, 2020, we called for the protection of residents with universal masking and pre-outbreak testing. Our call was not heeded until April 8, 2020.[2]



[3] **As we write this report, 84 per cent of all lives lost to COVID-19 are residents of Ontario's long-term care facilities. This is a shocking and tragic reality.[4]**

RNAO remains gravely concerned about all other vulnerable populations, including persons experiencing homelessness and living in shelters, persons living in supportive housing, persons housed in correctional facilities, and our Indigenous sisters and brothers. Authorities have been slow to protect these communities, extending histories and reconfirming past neglects.

Ontario Health, the province's lead health agency, states that its singular focus is to "enable the delivery of better quality health care to every Ontarian while offering the best possible experience at every step along your journey."[5] RNAO shares this lofty goal, and to achieve it, **Ontario must recalibrate its heavy focus on hospital care with much-needed and strengthened community care. This is where ECCO 3.0 is a clarion call for urgent change.**

ECCO 1.0 was first released in 2012.[6] That first version was discussed with then Minister of Health and Long-Term Care Deb Matthews, and was lauded by then Health Critic for the official opposition, Christine Elliott, and supported by the Leader of the Ontario New Democratic Party, Andrea Horwath. Despite initial praise, there was a lack of movement towards our vision, and RNAO issued ECCO 2.0 in 2014 with an updated human resources transition plan.[7] ECCO 1.0 and 2.0 called on both the government and health-system partners to strengthen community care and anchor the health system in primary care as a means to better meet the health needs of all Ontario residents. Eric Hoskins, Minister of Health in 2014, recognized ECCO 2.0 as a key document that influenced his thinking and his delivery of Putting Patients First, his action plan for better health care, released in 2015.

ECCO 3.0 was first conceived in early 2019, when the Ontario government announced plans to reshape the health system. **That announcement renewed RNAO's hope that reform would focus on enhancing community care in the province as a means of providing services and improving health outcomes for everyone.** The idea of OHTs, in particular, had many of the elements included in ECCO.

Now, after almost five months of the COVID-19 pandemic, we urge government – more than ever before and in the strongest possible terms – to incorporate the recommendations of ECCO 3.0 as we all engage in a retrospective analysis of the pandemic. This look into our rear-view mirror should help address our health-system performance as well as sector-by-sector successes, failures, experiences and outcomes. We've lost too many lives to COVID-19. Let's make sure those lives were not lost for naught. We owe it to them, to their loved ones, and to so many who sacrificed along the way – starting with our health-care workers – to draw from these lessons that will make for a better health-care system. **We need to speed up our health-system transformation – in a revised direction – so we can better respond to people's needs both in normal times and also during emergencies.**

In many respects, RNAO's call on government and stakeholders remains unchanged in this third version of ECCO. If anything, the current emergency context confirms the need for enhanced community care. Our vision of an accessible, equitable, person-centred, integrated and publicly funded health system will only be realized when we have a fully integrated health system anchored in primary care with enhanced community care capacity. This is a reachable goal with the current health-system reform approach based on OHTs.

In ECCO 3.0, we adapt our model to align with the creation of a single health-system administrator (Ontario Health) and multiple integrated care delivery organizations (Ontario Health Teams (OHT).

This report is divided into three sections. The first sets out the context for the ECCO model, including RNAO's vision for a healthy Ontario, the current state of our health system, drivers for change, including social and environmental determinants, and ongoing health-system reforms. The second section discusses the ECCO model and its alignment with health-system restructuring. The third section sets out RNAO's recommendations and actions required to realize health-system reform built around enhanced community care.

**In total, we offer 13 recommendations with accompanying action items, which we believe will result in enhanced community care and better quality care for all Ontarians.** Nine of these recommendations are paramount to achieving the goals of ECCO 3.0, while four of the recommendations are titled 'transition recommendations' and are necessary to move from the current state to the transformed health system.

(1) **RECOMMENDATION 1: Expand the reach of and access to primary care to ensure all Ontarians are linked with a primary care team**

- Build relationships between primary care teams and community members.

- Incorporate equity tools in planning and evaluating services.

- Remove barriers to primary care.

- Extend primary care services into atypical settings, such as shelters and streets.

(2) **RECOMMENDATION 2: Establish approaches to care that are person-centred, incorporate health promotion and disease prevention, and integrate equity and community engagement**

- Incorporate person-centred care across the health system.

- Leverage the expertise of public health to inspire and inform population health planning and accountability.

- Fund primary care models based on the implementation of a primary health-care approach, inclusive of upstream social and environmental determinants of health.

(3) **RECOMMENDATION 3: Ensure all primary care is provided through an interprofessional team-based model**

- Expand interprofessional team-based models of primary care by increasing patient enrollment across existing models and creating new sites where there is a need.

- Place a moratorium on new independent practice models of primary care.

- Connect all existing primary care providers to interprofessional teams.

(4) **RECOMMENDATION 4: Make comprehensive care co-ordination, based in primary care, available to all Ontarians 24/7**

- Locate the care co-ordination function in primary care.

- Transition all RN care co-ordinators currently employed by Ontario Health (previously Local Health Integration Networks (LHIN) to interprofessional primary care teams.

- Expand the care co-ordinator role to provide comprehensive and consistent service for all Ontarians.

- Support the work necessary to determine appropriate care co-ordinator case load to reach all Ontarians.

**(5)** **RECOMMENDATION 5:** **Enhance all community care services across the continuum of care**

- Augment the capacity of primary care to address mental health and addiction.

- Invest in improving the availability and quality of community based mental health and addiction services.

- Ensure robust home and community care services.

- Transition the responsibility for home-care services directly to home-care agencies.

- Reform the home-care funding model from a per-visit basis to funding baskets to allow a person-centred approach that encompasses a range of nursing interventions, including health promotion and ensuring continuity of care and continuity of caregiver.

- Ensure home-care contracts are awarded to providers that are able to deliver a broad range of services around the clock, so as to avoid fragmented care.

- Optimize the health system to better connect people to the range of social services necessary for health and well-being.

**(6)** **RECOMMENDATION 6:** **Re-imagine long-term care (LTC) as 'home' to residents, and integrate nursing and retirement homes into enhanced community care plans and funding**

- Require that all OHTs incorporate LTC as part of their team configuration, such that all LTC facilities are actively connected to the full health system.

- Incorporate a focus on the person-first philosophy, planning care and services according to an individual's needs and wishes rather than those of the medical care model.

- Modernize the funding formula in LTC – immediately – to account for complexity of care needs and quality outcomes.[8][9]

- Modernize staffing in nursing homes immediately.[8][9]

- Develop new and renovated nursing homes for persons with dementia, with special consideration to smaller congregates of up to seven residents per house, and with design based on resident preferences.
    - Example: *De Hogeweyk* – A gated model village in Weesp, Netherlands, which already exists in Canada's first community designed specifically for people with dementia in Langley, British Columbia.[10][11][12]

**(7)** **RECOMMENDATION 7:** **Demonstrate a commitment to evidence-based practice across the health system**

- Support staff engagement in the implementation of evidence-based practice.

- Use best practice guidelines (BPG) to inform care delivery.

- Enable integrated and person-centred care through the use of RNAO BPGs.

- Monitor and evaluate the impact of the implementation of evidence-based practice.

- Reinvest all savings from improved outcomes in direct care.

**( 8 )** **RECOMMENDATION 8: Optimize digital health technologies to improve access, enhance integration and support person-centred care**

- Establish a standardized and shared system for collecting data and disseminating population health information across the system.

- Develop and maintain a province-wide strategy to make electronic personal health records available to all Ontarians based on the principles of accessibility, security, comprehensiveness, patient-control, and publicly-funded and administered.

**( 9 )** **RECOMMENDATION 9: Maximize and enable the full scope of practice of all regulated health professionals**

- Implement legislative and regulatory changes to maximize appropriate and safe scope for regulated health professionals.

- Remove organizational barriers that prevent regulated health professionals from working to their full, legislated scope of practice.

- Provide resources to enable regulated health professionals to enhance their individual knowledge, skill and judgment and develop competency in their full scope.

**( 1 )** **TRANSITION RECOMMENDATION 1: Include primary care in a leadership role in the process of transforming the health system**

- Embed primary care leadership into the OHT application process and ongoing performance management.

- Establish the Ontario Primary Care Council as a regional primary care advisory table.

- Re-locate the ministry of health's primary care branch to Ontario Health.

- Maintain strong focus on primary care at the ministry of health.

**( 2 )** **TRANSITION RECOMMENDATION 2: Use a funding model for OHTs that drives them to realize the Quadruple Aim**

- Provide adequate funding for health care.

- Structure health-system funding to meet the objective that, by 2022, all Ontarians receive care through OHTs.

- Design all funding and compensation schemes to promote:

  o the Quadruple Aim (improved patient experience, improved patient outcomes, lower cost of care, and improved provider experience),

  o the delivery of all necessary health services,

  o the realization of a health system rooted in interprofessional primary care,

  o the development of a totally integrated health system with multidisciplinary teams that fully utilize the education and training of all health-care providers.

- Incorporate risk-based capitation and ensure it is evidence-based and experience-informed, and incents inclusion of all Ontarians – including vulnerable populations – in OHTs. That means risk-adjusting for social determinants of health like income and core housing needs.

- Supplement risk-based capitation with bundled-care funding that is evidence-based and experience-informed and used appropriately: there must be clear clinical pathways and the funding must incent full and consistent care throughout health episodes.

- Preserve funding levels through return-of-savings to front-line health-care services.

- Ban fee-for-service billing direct to the ministry of health that would incent an expansion of fee-for-service physician-based primary care services.

- Incent participation of social-service providers, such as housing, in OHTs.

- Structure the OHT-funding models such that they strengthen the public, not-for-profit nature of Ontario's health system.

- Continue with professional, arm's length attribution of residents to the most appropriate OHT, reflecting resident choice of primary care provider.

**(3) TRANSITION RECOMMENDATION 3: Develop a single health-system planner and funder that oversees and supports networks of local health teams, allowing for enhanced health services and processes that realize the Quadruple Aim**

- Operationalize Ontario Health as the single health infrastructure responsible for system-wide planning, funding allocation, monitoring and evaluation, and related functions.

- Prohibit involvement of Ontario Health in direct service delivery and management.

- Require that OHTs have a strong primary care foundation.

- Hold OHTs accountable for providing person-centred and co-ordinated health services that promote health, prevent injury and disease, and manage and treat acute, chronic, and palliative care needs.

- Initiate and implement a labour-relations strategy that allows for the transition of all direct health-care services and service providers currently in Ontario Health regional offices (previous LHINs) to primary care or community based organizations, while respecting collective bargaining rights, collective agreements and worker entitlements.

**(4)** **TRANSITION RECOMMENDATION 4: Align independent public health entities with the integrated health system, while increasing the overall funding to public health**

- Increase the overall funding to public health units (PHU) and maintain the current 75/25 provincial/municipal split so that PHUs can:

  - provide stronger and more consistent leadership while delivering an emergency preparedness response for all sectors and all communities, especially vulnerable populations,

  - design and deliver population health programs that advance health equity.

- Amalgamate PHUs into a reduced number of public health entities and ensure each has the necessary expertise and capacity.

- Align the new public health entities with the geographical boundaries of Ontario Health regional offices, OHTs, and municipal boundaries.

- Require autonomous boards of health for each of the new public health entities to reflect the local population, and include membership from citizens and municipalities.

- Retain public health leadership of a chief executive officer (CEO), medical officer of health (MOH) and chief nursing officer (CNO) for each public health entity.

- Fully involve the CNO and nurses in the public health transformation agenda.

- Engage public health as an active partner in health-system transformation through close collaboration and formal linkages between public health entities, Ontario Health regional offices, and OHTs.

- Create formal linkages between Public Health Ontario (PHO) and Ontario Health.

Nurses believe the implementation of the ECCO 3.0 model is urgently needed to realize the healthy Ontario that we all desire. Pre-Covid-19 plans for health-system restructuring in Ontario are compatible with RNAO's vision of enhanced community care. Ontario Health and OHTs have been put to the test during COVID-19, and so have all health sectors, all health workers, and Ontarians-at-large. Strengths and weaknesses have been exposed.

**There is a crying need to enhance community care as we take stock of lessons-learned during COVID-19.** Precious lives were lost due to weaknesses in our health system, in particular the neglect of congregate settings such as nursing homes, retirement homes and shelters. We must seize the moment to build a stronger health system for all who call Ontario home.

# INTRODUCTION

*Enhancing Community Care for Ontarians* (*ECCO*) sets out the Registered Nurses' Association of Ontario (RNAO) vision for community care services that better meet the needs of the people of Ontario.

While RNAO would never seek to abolish hospitals, we urge government and its agencies to recalibrate the health system from one that over-relies on and over-utilizes hospitals to the detriment of all other sectors. This has a negative impact on Ontario residents and our overall health system performance.

RNAO first presented this model with the release of its landmark report *ECCO 1.0* in 2012.[6] in 2014, RNAO issued ECCO 2.0[7] ahead of the health-system changes that took place then.[6] RNAO now presents ECCO 3.0 – a model of enhanced community care that aligns with a single health system administrator (Ontario Health) and multiple integrated care delivery organizations (Ontario Health Teams (OHT)).

Consistent through RNAO's successive models of enhanced community care are the changes necessary to strengthen Ontario's community care services and, in particular, the primary care system so it serves as the anchor of our health system. **An accessible, equitable, person-centred, integrated and publicly funded health system, delivered primarily on a not-for-profit basis, can only be realized when we have a robust community sector that anchored in primary care has those same attributes.**

RNAO is releasing ECCO 3.0 following the Ontario government's recently launched health-system transformation agenda, and after five months of exposure to COVID-19, which has tested our health-system performance. Changes across the health system have been implemented or are underway to realize the government's vision of an integrated care-delivery system built around Ontario Health, its five regional offices, and dozens of local, territorially defined OHTs that will cover the province. The transformation underway will take time to reach maturity. Change will be the norm until then – even more so as adjustments to plans are made to account for successes and failures during the COVID-19 pandemic.

The OHT framework, presently being implemented as part of Ontario's health transformation agenda, provides an ideal opportunity to better anchor the entire system in primary care, with strong and robust links to all sectors of the system. In our current situation, amidst a major pandemic, much of the primary care and community based components of the health system have been virtually shut down and deemed as dispensable. Such an imbalanced approach to guarding the health of the population has left a huge majority of Ontarians without services that are necessary in managing chronic conditions, preventing exacerbations, enabling early detection and promoting overall health.

In the aftermath of COVID -19, the key tenets of the transformation agenda must be strengthened. Moreover, we must move forward with even more solid integration of primary and community care by ensuring that, in the OHT framework, all sectors are equally robust and that we anchor OHTs in primary care. Building such a system of primary care must be a priority now so as to be ready for the second and third waves of this deadly COVID-19 pandemic. There are exemplars currently in place where swift action using a primary care model, combined with home health care, was able to stem major outbreaks and keep the pandemic at bay. For example, **the Balearic Islands, an archipelago in the western Mediterranean Sea, and an autonomous community (a province) of Spain, where COVID-19 hit hard, was successful early on in flattening the curve.[14] Its ammunition was use of a primary care approach to contain the spread of the disease.** Through rapid mobilization of its entire primary care system, differentiating COVID-suspected patients and those without symptoms, and using key primary health supports -- augmented by home health care -- it was able to carry out major outreach, public education, tracking, self-isolation, and surveillance.[14] Central to the success of this system was early oversight and control of nursing homes, where daily interventions and testing of both vulnerable patients and health-care workers was carried out with referral of patients to hospital when required.[14]

This early, comprehensive primary care intervention helped contain the outbreak in the home care sector, thus protecting hospitals from collapse and allowing them to focus their efforts on the people severely affected by the disease. The organizing values for primary care as a gateway to the health system were defined as: accessibility, proximity, efficiency and resolution. This kind of primary care approach allowed hospitals to adopt the necessary structural and organizational measures to adequately care for patients affected with COVID-19, as well as maintain care and treatment not linked to the pandemic. All of this was accompanied by an extraordinary increase in home and telephone care (in primary care and in hospitals), allowing the decongestion of the two health-care areas.

From RNAO's perspective, this is an insightful example of an approach that emphasized keeping the health system whole for all. It limited the spread of COVID-19 early on by keeping people at home, including for purposes of getting tested. It promoted people's active support by ongoing telephone connection and extensive home-care visits. The use of social media for virtual consultation with professionals is not something we have tried in Canada, nor is the intensive daily monitoring of COVID+ persons with extensive, quick contact tracing and isolation. A co-ordination centre for COVID response, led by primary care professionals, is a crucial element for us to consider in the go-forward. The same holds for a reorganized health system of community care anchored in primary care and augmented robustly by home care, with responsibility for the totality of the population.

RNAO presents *ECCO 3.0* within this context. Our goal is to inform transformation plans and offer key performance indicators for measuring progress throughout an urgently needed makeover. RNAO urges that we not miss the opportunity to continue transforming Ontario's health system as we move past the COVID-19 pandemic. **Many will be tempted to wait for a second and perhaps a third wave of COVID-19 before triggering change. This should not be the case.** The entire community care sector must be substantively strengthened and fully operational to serve Ontarians once again. It must become anchored in primary care and move away from complete reliance on hospital care and hospital infrastructure.

To support the health and well-being of the people of Ontario, RNAO envisions a health system that is accessible, equitable, person-centred, integrated and publicly funded:

*Dr. Doris Grinspun,
RNAO CEO,
COVID-19 Press
Conference on
March 11, 2020*

# RNAO VISION

- **Accessible** – Ontarians are connected to interprofessional care teams that provide care in the communities where people live, work and play. Primary care, set in the community, is the first point of contact with the health system, with connections and support across all sectors and services.

- **Equitable** – The health system takes action and is accountable for decreasing gaps in health outcomes, services and experiences between Ontarians. This is achieved by a health system that reaches out into the community, modifies services to the needs of the community, assesses and reports on the impact of health determinants, and works in partnerships across health and social sectors.

- **Person-centred** – The system is designed around the needs of those it serves, with persons viewed as whole and powered people, along with their support system, as genuine partners in their own health and health care. Care decisions and services are driven by what an individual wants and needs.

- **Integrated** – Care is continuous, comprehensive and co-ordinated, with seamless transitions from sector to sector and service to service. Care co-ordination is based on primary care, where people first enter the system.

- **Publicly funded** – Adequate public funding to ensure everyone has access to health care. Equitable access to health care is affordable and sustainable. For this, preference for not-for-profit care delivery is paramount, as it enables better quality care at a lower cost.

Based on these key attributes, the ECCO model is made up of integrated networks of local health teams founded in enhanced community care, anchored in primary care, supported by and accountable to a single, publicly funded and government administered health system. Within the context of the current health-care reforms, RNAO sees the opportunity for Ontario Health to act as the single health system infrastructure that oversees and supports networks of local health teams – Ontario Health Teams (OHT). The OHT model presents an opportunity to break the silos of the current system and provide the public with a more accessible, equitable, person-centred and integrated health-care experience.

**The critical question – which has been asked since the release of *ECCO 1.0* in 2012 – is whether the government will strengthen community care and establish primary care as the anchor of our health system, locating the care co-ordination role within it.** Doing so is a marker of any high performing health system, and is central to improving access, equity and integration while providing person-centred care that delivers optimal health outcomes.

# CURRENT CONTEXT

As outlined in this upcoming section, key performance indicators, and our response to COVID-19, which revealed a set of siloed and sidelined sectors, tell us loud and clear that Ontario's health system could – and must – do better. Also troubling is that social and environmental determinants of health are heading in a direction that will place even heavier burdens on our health system in the future.

### Health system and care delivery

The government of Ontario has identified transformative change to our health system as a priority. It has been clear, for example, about its commitment to address hallway health care. This problem – of about 1,000 people receiving care in the hallways of Ontario hospitals at any given point in time pre-COVID-19 – is one indicator of the capacity pressures the system is experiencing.[16] The problem starts in primary care, where 60 per cent of Ontarians report not having timely access to their primary care provider when they are sick.[17] This number has been increasing over the past six years.[17] When people can't see their primary care provider, they often go to walk-in clinics or the emergency department. **In 2018, 41.7 per cent of people who visited an emergency department said their primary care provider could have handled the issue of the most recent visit, had their provider been available.**[19]

The challenge of accessing primary care has ripple effects. The past six years also saw an 11.3 per cent rise in emergency department visits.[18] In 2017/2018, 9.5 per cent of Ontarians who visited the emergency department for mental illness or addiction visited four or more times in one year. Once in emergency, if needing ongoing hospital treatment, people spend an average of 15.6 hours before being admitted to the hospital.[19] At the other end of the hospital visit, there are an increasing number of hospital beds being used for people who are waiting for care elsewhere. Nearly 15 per cent of patients in Ontario hospitals are waiting for alternative levels of care, such as long-term care homes or rehabilitation facilities.[17]

Hallway health care that is on the rise, and emergency department overcrowding, are indicative of a system under strain that is lacking the community services and supports to meet the needs of Ontarians, notably with respect to mental health and addictions.

### Nursing and fiscal capacity

Access to Ontario's health system is not simply a function of its structure but also of chronic underfunding. The Financial Accountability Office of Ontario has shown that the province has the lowest per capita program spending in Canada ($9,829 in 2017 vs. $11,862 in the rest of Canada).[20] For 2018-19 and 2019-20, the Royal Bank of Canada put Ontario's per capita program expenditures in last place.[21]

This tendency is reflected in Ontario's health-care spending. **Ontario's average public spending on health per person is below the national average, and the gap has been growing since 2008.**[22]

## ONTARIO VS. REST OF CANADA: PUBLIC SPENDING ON HEALTH, ADJUSTED FOR AGE AND SEX
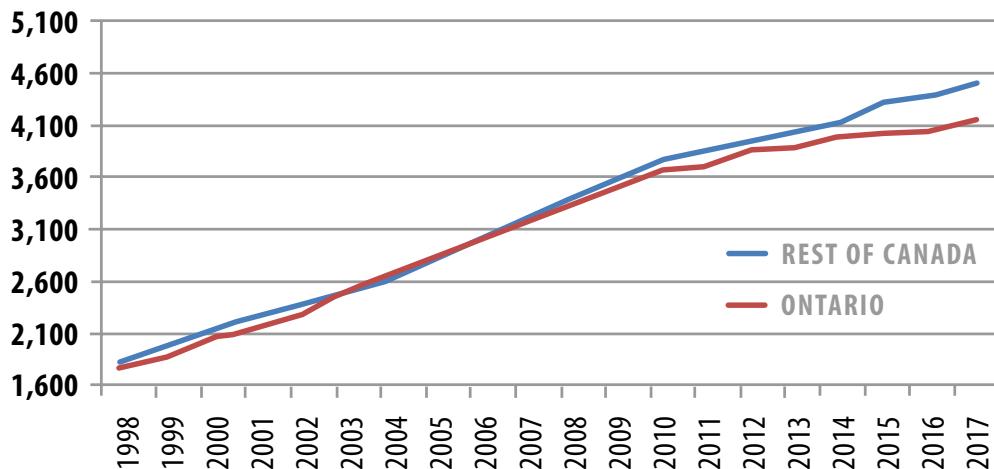


Registered nurse (RN) employment levels are particularly sensitive to program spending. Austerity measures in the health system have materialized in the form of both lower nursing employment and a shift in skill mix away from RNs to lower-skilled registered practical nurses (RPN). As a consequence of chronic health-system underfunding, access to care and co-ordination of care have been compromised.

### *Social and environmental determinants of health*

The context in which our health system operates is not static. There are important social and environmental determinants of health that must be accounted for because these determinants are the underlying factors and conditions that shape health (see Appendix A). These trends are an indication of the health and well-being of our province, and they forecast the demands that will be placed on our health system in the future. RNAO concludes that social and environmental determinants of health are trending in a direction that supports the call for urgent enhancement of community care in Ontario.

# HEALTH-SYSTEM REFORM

*ECCO 3.0* is intentionally released in the midst of ongoing health transformation initiatives pre-COVID-19 and as we make our way through the COVID-19 pandemic. We do so for the purpose of taking stock of the proposed changes, and to advance a health system that is accessible, equitable, person-centred, integrated and publicly-funded. We have maintained our original target release date for *ECCO 3.0* to highlight how management of a major crisis like COVID-19 has been severely compromised by a (current) system that lacks integration and is centred on hospital care to the detriment of the system as a whole.

> "Ontario is significantly expanding hospital capacity by adding 1,035 acute care beds and 1,492 critical care beds to help prepare for any #COVID19 outbreak scenarios."
>
> – Ontario's Ministry of Health, April 16, 2020[23]

The centerpiece of health-system reform in Ontario has been the introduction – through *The People's Health Care Act, 2019* and *The Connecting Care Act, 2019* – of an integrated care-delivery system for Ontario that includes Ontario Health, its five regional offices, and dozens of local, territorially-defined OHTs that will cover the province. This legislation represented a vision of a connected health-care system centred around patients, families and caregivers that is easier to navigate and with strengthened local services.[24]

The government positioned Ontario Health, a single provincial agency with five regional offices, to take on the primary functions of measuring and managing health-system performance, population-based programming and clinical and quality standards, and back office support and oversight.[25] In this role, Ontario Health is taking over and co-ordinating the work of existing provincial health agencies and programs, including the 14 Local Health Integration Networks (LHIN), Cancer Care Ontario, Health Quality Ontario, eHealth Ontario, Trillium Gift of Life Network, Health Shared Services Ontario, and HealthForceOntario Marketing and Recruitment Agency.[25] A Mental Health and Addictions Centre of Excellence has been subsequently established within Ontario Health to provide central oversight for mental health and addictions services in the province.

The government further positioned OHTs to be responsible for the organization and delivery of health services in local communities. In this role, groups of health organizations and providers are being asked to voluntarily self organize and work collaboratively to form local health networks, each representing at least three sectors.[26]

A companion initiative to the implementation of an integrated care-delivery system has been the creation of The Premier's Council on Improving Healthcare and Ending Hallway Medicine. Led by Dr. Reuben Devlin, the Council was convened in 2018 and has released two reports, including recommendations that point to a more integrated health system anchored in primary care. For more detail on the Council and other recently implemented and/or ongoing health system transformation initiatives, see Appendix B.

The desired model of a single provincial agency – Ontario Health – is a step in the right direction. However, the COVID-19 pandemic has demonstrated that there are still substantial shortfalls in the primary functions assigned to this agency. Primary concerns have been the inadequate stock and distribution of personal protective equipment (PPE) and the inadequacy of back office support and oversight for backfilling health human resources.

> "When asked about the factors that would help reduce anxiety, 88% of physicians surveyed selected 'greater PPE availability'"
>
> – Canadian Medical Association, April 29, 2020[27]

COVID-19 also revealed a health system in Ontario that relies excessively on hospital care and neglects other sectors until it's too late. Public health units performed unevenly and inconsistently. Primary care offices remained mostly closed. Home health care received little attention. And nursing homes and retirement homes received vigourous attention only after 500 lives had been lost. Outbreaks in shelters, correctional facilities, and Indigenous communities are only now being identified as we write this report.

**Our summary position is that Ontario's overall performance during COVID-19 calls for speeding up the formation of OHTs, with a clear mandate of full and urgent integration of all sectors and populations.**



Improved patient experience — Improved provider experience — QUADRUPLE AIM — Lower cost of care — Improved patient outcomes
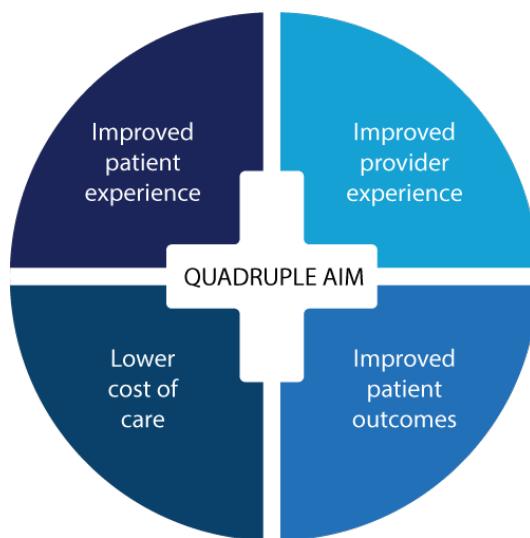
# ECCO MODEL

It is in this context of uneven health-system performance, especially during the COVID-19 pandemic, worrying trends in health determinants, and ambitious system transformation that RNAO re-introduces its model for enhanced community care.

The foundation for RNAO's ECCO model is an integrated system of care with a strong community care sector anchored in primary care. The focus on primary care is supported by evidence from around the world that demonstrates high-functioning health systems are founded on strong primary care. **Strong primary care sectors are associated with improved patient experiences, reduced morbidity and mortality, better equity, and lower overall health-care costs**.[28] [29] [30] [31] [32] [33] [34]

**What is primary care?**

Primary care is the foundational level of the health system that provides entry into the health system. Primary care provides person-centred (not disease-oriented) care over time for most health needs and conditions by delivering services across the continuum of care to maximize the health and well-being of all people. Primary care forms the foundation for and determines the work of all other levels of the health system, and has a central role in co-ordinating and integrating care provided across the system.[35] [36]

SCHOOL

PUBLIC HEALTH

HOSPITAL

SOCIAL SERVICES

HOME CARE

REHAB & COMPLEX CARE

COMMUNITY SUPPORT SERVICES

Person-centred care coordination and health system navigation

MENTAL HEALTH & ADDICTION SERVICES

OTHER HEALTH SERVICES

PRIMARY CARE

LONG-TERM CARE

**PRIMARY CARE IS THE FOUNDATION OF THE ONTARIO HEALTH TEAMS**
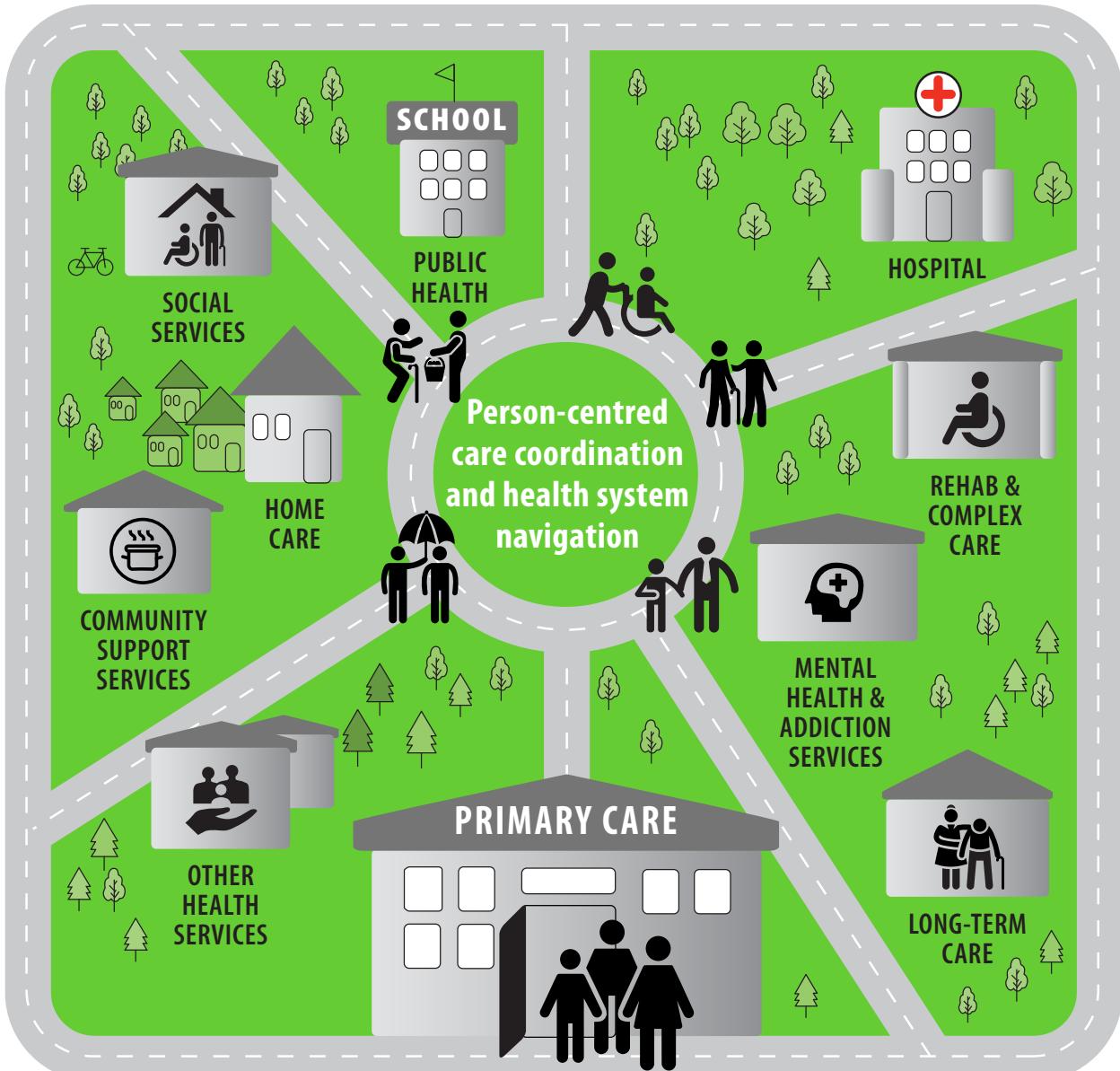
*Figure 1 – ECCO Model*

# KEY ATTRIBUTES OF THE ECCO MODEL

The ECCO model envisions a transformed health system with strengthened community care services, and with a primary care sector at its foundation that is accessible, equitable, person-centred, integrated and publicly-funded.

## Accessible

As the foundational sector of the health system that is located throughout the community, primary care is essential to providing universal access to health care. Its ability to fulfill its function as the primary entry point to the health system requires that:

- Primary care reaches out into a broad spectrum of settings - including atypical health-care settings such as shelters and streets.

- Primary care is provid ed through an interprofessional care model.

- Primary care provides comprehensive care and continuity of care in the forms of disease prevention and health promotion, diagnosis, treatment and management across the lifespan for all health needs.

- Primary care is responsible for the central function of care co-ordination. This is essential to support all Ontarians in accessing and navigating the health system's different sectors and services, especially during care transitions.

- All regulated health professionals – including nurses – work to their full scope of practice to facilitate timely access to care.

## Equitable

A health system designed to improve the health of all Ontarians demands efforts to decrease avoidable and unfair gaps in health between groups of people – irrespective of identity or geographic area. This pursuit of health equity begins in primary care as it is the sector best positioned to extend into the community to ensure that all people – including those who experience marginalization or are hard to reach – are provided with and connected to the services they need. This requires that:

- Primary care reaches out to everyone to provide appropriate and timely care. This involves modifying and orienting services based on unique needs of populations that experience marginalization. This can involve providing services in non-traditional health settings, such as shelters and on the street. Services may also need to expand beyond what has traditionally been considered health, to those that mitigate the non-clinical factors that determine health, such as poverty.

- Primary care assesses and reports on the existence and impact of the determinants of health of the people it serves, and is accountable for decreasing health inequities. Determinants of health include the upstream, non-clinical factors and structures that create the conditions for and shape of health and well-being.

- Primary care works in partnership and collaboration across the health system and across sectors to improve health outcomes for everyone – especially populations that experience marginalization.[37] [38]

## Person-centred

Primary care is the foundation of a person-centred approach, where the principal relationship between a person and their team of health providers is developed and maintained. Person-centred care requires that:

- People are recognized and valued as whole persons. This is a move away from the bio-medical model of viewing people only as patients with symptoms or disease requiring diagnosis and treatment.

- Interactions between people and their providers should be centred around their experience of health over time, and understood in the context of their identity, history, experiences, needs, abilities and hopes.

- Power is shared between people and providers. This means people are valued and empowered as experts in their own lives and partners in health care. Care decisions and services are driven by what the person wants and needs.[39]

## Integrated

An integrated health system requires a foundation in primary care to enable continuous, comprehensive and co-ordinated care. It is primary care that is best positioned to enable integration across the system through its role in the community. This requires that:

- Interprofessional care and access to the full continuum of care is available where people enter the health system.

- Care co-ordination for all services and sectors is located in the community where people live and first access the system.

- Primary care teams build effective linkages and connections to the broader health and social system.

- Evidence-based care is supported and provided to improve the quality of care and outcomes across the health-care continuum.

## Publicly funded

Our health system cannot provide health services adequately if the provision of those services is dependent on profit. Adequately resourced, a publicly funded and primarily not-for-profit model will ensure health care is provided to everyone, no matter their means. Not-for-profit delivery of health services is associated with better health outcomes and lower costs.[40]

A health system with a strong primary care foundation is best placed to ensure quality care with positive health outcomes that are cost-effective. It allows for early and appropriate interventions that decrease the demand for acute and specialized care, which are more expensive. By investing in accessible, timely, appropriate, equitable, high-quality, comprehensive, and evidence-informed programs and services in primary care, the demands on the rest of the system will decrease and the health of Ontarians will improve.[41]

## EXPERIENCING THE ECCO MODEL—meet Taylor

When Taylor moved to a new community, she connected with a primary care provider of her choosing and got an appointment after one phone call. At her first appointment, she met the care co-ordinator and other interprofessional team members at the primary care organization, with whom she developed relationships through ongoing contact.

Taylor was provided comprehensive care at her regular appointments, including prevention (immunizations and screening tests) and health promotion (education on healthy eating and safer sex). When sick, she was able to get an appointment on the same or next day. One time, when she felt burning when she urinated, she saw her provider for an assessment and testing, was diagnosed with a bladder infection, and left with a prescription for antibiotics and knowledge of ways to prevent recurrence.

There was also a time when Taylor was experiencing stress and anxiety, and having difficulty sleeping. During a routine appointment, her care provider asked about her mental health, and discussed available supports in the community to meet her needs. Taylor practised the coping skills she learned during that appointment. When she needed additional support, she connected virtually with her care co-ordinator, who referred her to mental health services in close proximity to her workplace. The care co-ordinator followed up regularly. Taylor was able to access her personal health record and contributed to this record by tracking her mood with daily entries. This personal health information was reviewed with her counselor during appointments, and was accessible to her primary care provider, which avoided unnecessary repetition in assessments.

When Taylor's dad had hip surgery, she was involved in discharge planning with his care co-ordinator to get home and community care services arranged promptly. The care co-ordinator helped the family navigate and organize care, provided ongoing support, and was a critical link between the hospital specialists and primary care team.

# ECCO IN THE CONTEXT OF HEALTH SYSTEM REFORMS

RNAO is encouraged by the overlap between the ECCO model and current health system reforms. However, in the absence of greater emphasis on establishing primary care as founda-tional to all OHTs, current health transformation will fall short of the ECCO model and RNAO's vision for a healthy Ontario.

*Table 1 – Comparison of Ontario Health and ECCO*

| Elements | Ontario Health Agency[25] & Ontario Health Teams[26] | ECCO model | System imperatives reinforced in ECCO |
|---|---|---|---|
| *Purpose* | A connected health-care sys-tem centred around patients, families and caregivers that makes it easier to navigate the system and strengthens local services. | A health system with strengthened primary care at its foundation that is accessible, equitable, per-son-centred, integrated and publicly-funded. | Primary care is the founda-tional sector of the health system.<br><br>The health system remains publicly funded. |
| *Primary func-tion* | Ontario Health<br><br>• System management and performance<br><br>• Population-based pro-grams and clinical and quality standards<br><br>• Back office support (e.g. supply chain manage-ment)<br><br>• System oversight<br><br>Ontario Health Teams<br><br>• Organize and deliver all health services in local communities | A single health system plan-ner and funder for all health sectors.<br><br>Local health networks representing all health sec-tors with a strong primary care foundation, and with connections to additional community supports and services. These networks provide direct service deliv-ery and management.<br><br>Primary care connects all Ontarians to interprofes-sional team-based care and comprehensive care co-ordination. | Primary care is strength-ened by connecting all primary care providers to interprofessional team-based care.<br><br>The care co-ordination function is located in prima-ry care. |

| Elements | Ontario Health Agency[25] & Ontario Health Teams[26] | ECCO model | System imperatives reinforced in ECCO |
|---|---|---|---|
| *Key stakeholders* | The Ontario Health Agency, including its five regional offices, will co-ordinate the work of existing provincial health agencies and pro-grams.<br><br>100+ Ontario Health Teams (OHT) are groups of providers voluntarily working together as a local health network. Each OHT must represent at least three sectors. | A single health oversight agency.<br><br>Local health networks are comprised of all community care and institutional care services. Primary care plays a foundational role and is connected to additional community supports and services. | Primary care organizations play a foundational role in all OHTs, both in the leader-ship and governance of the network and in co-ordinat-ing care across the health system. |
| *Defined popu-lation* | When the OHTs are fully established, to cover all Ontarians. | All Ontarians. | Primary care to reach into community (eg. street nurs-ing) and unconventional settings (eg. shelters) to en-sure vulnerable populations receive the care they need. |

The need for the current health system reforms to place greater emphasis on primary care is supported by the second report of the Premier's Council, titled *A Healthy Ontario: Build-ing a sustainable health care system*. In this report, the Council recognized the necessity of a strengthened primary care sector as the foundation of Ontario's health-care system as out-lined in recommendation 3 (pg. 26):

"Support patients and providers at every step of their health-care journey by ensuring effective primary care is the foundation of an integrated health care system."[42]

# RECOMMENDATIONS

A health system that follows the ECCO model, with strengthened primary care at its foundation, and that is accessible, equitable, person-centred, integrated and publicly-funded, is possible by adopting the following recommendations:

**(1)** **RECOMMENDATION 1: Universal reach**

Expand the reach of and access to primary care to ensure all Ontarians are linked with a primary care team.

Action items:

- Build relationships between primary care teams and community members.
- Incorporate equity tools in planning and evaluating services.
- Remove barriers to primary care.
- Extend primary care services into atypical settings, such as shelters and streets.

A strong primary care sector starts by expanding reach and access to ensure all Ontarians are linked to a primary care team in their community. The goal is for 100 per cent of Ontarians to be connected to primary care. A primary focus of primary care must be vulnerable populations, including older persons, to support them staying as vibrant members of our communities. Primary care should also remain connected once individuals enter alternative living arrangements, such as retirement homes and nursing homes. Similarly, primary care is central to ensuring the well-being of persons living in supportive housing. The role of primary care is paramount to support the health of vulnerable populations experiencing homelessness, and help their chances of attaining housing. And, primary care must be strengthened in Indigenous communities' health systems.

> "Primary care clinics are closed [during the COVID-19 pandemic] because don't have PPE. As economy re-opens, need care available and need PPE for ALL primary care. What is the plan to address this?"
>
> – Ontario Medical Association, MEOC meeting, May 7, 2020[43]

This can be achieved by primary care investing in building and maintaining relationships with community members and community organizations. We also need community led governance models that involve communities in the design and delivery of care. Further, building on these relationships, it is necessary to embed equity considerations into planning and evaluation of care and services. Planning and evaluation tools can measure how populations are being reached, and whether services are appropriate for the needs of community members. This work can help inform potential barriers to access, which then need to be mitigated. For example, this may require considerations based on:

- Location – offering outreach services and expanding virtual-care options

- Timing – increasing hours to include evenings and weekends

- Cost – eliminating any and all user fees

- Diversity – ensuring services are appropriate for the language, literacy, cultural and other needs of community members

- Safety – developing and implementing anti-oppression practices

**(2)** **RECOMMENDATION 2: Upstream approach to care**

Establish approaches to care that are person-centred, incorporate health promotion and disease prevention, and integrate equity and community engagement.

Action items:

- Incorporate person-centred care across the health system.

- Leverage the expertise of public health to inspire and inform population health planning and accountability.

- Fund primary care models based on the implementation of a primary health-care approach, inclusive of upstream social and environmental determinants of health.

The health system must be further strengthened by applying approaches to care – at all levels – that centre around people, span upstream and downstream health interventions, and integrate equity and community engagement. Starting in primary care, a health system can be designed around the needs of those it serves by adopting person-centred care across the system. **Person-centred care is an approach that views people as whole persons and leaders in the care delivery process.** It starts by planning and delivering services based on where people are, and builds on this through advocacy, empowerment, respect for autonomy, self-determination and participation in decision-making.[40]

At the system-planning level, this must also involve a population health approach. A population health approach to improve health and well-being is action directed toward the health of an entire population that integrates the determinants of health and its interactions, involves community engagement, and demonstrates accountability for equitable health outcomes.[44] The expertise of public health can be leveraged to inspire and inform population health planning and accountability.

At the individual and community level, this means a primary health-care approach to improve health and well-being. A primary health-care approach encompasses the full spectrum of health services and has a community orientation and focus on equity.[45] [46] This includes health promotion and protection, injury and disease prevention, and diagnosis, treatment and management across the lifespan for all health needs, including mental health and chronic disease prevention and management. This approach, with people and community at its core, is *not* how most primary care is delivered in Ontario currently.[46] Funding of primary care must be based on this approach to ensure comprehensive primary health care exists throughout the sector, and is expanded across the health system.

( **3** )    **RECOMMENDATION 3: Interprofessional primary care teams**

Ensure all primary care is provided through an interprofessional team-based model.

Action items:

- Expand interprofessional team-based models of primary care by increasing patient enrollment across existing models and creating new sites where there is a need.

- Place a moratorium on new independent practice models of primary care.

- Connect all existing primary care providers to interprofessional teams.

Primary care must be strengthened to ensure comprehensive care is provided at the first point of contact. Continuity of care is improved through consistent interactions with care teams, and through connections between health sectors and services, as well as enhancements to other community and social supports. This starts by expanding interprofessional team-based models of primary care.

In the ECCO model, Ontarians mainly access interprofessional team care through their primary care provider (PCP). The role of the PCP is to be a principal provider of health care. A PCP is typically a family doctor or nurse practitioner (NP). **Each Ontarian should have a relationship with a PCP of their choosing, and through this relationship, access to an interprofessional team, including a care co-ordinator.** This is not currently the case in Ontario. While 94 per cent of Ontarians have a regular PCP,[47] only 45 per cent of PCPs are connected to interprofessional teams and specialists.[48]

Primary care that is organized and provided through interprofessional teams currently exists in Ontario through several models: family health teams (FHT), community health centres (CHC), Aboriginal health access centres (AHAC), and nurse practitioner-led clinics (NPLC). Of these models, FHTs – which most often take the form of family health networks or family health organizations – have been preferred by government and the medical profession since this model was introduced in 2004.[49] FHTs are primarily physician-led with funding through a mixture of capitation, fee-for-service, and bonuses, premiums and special payments.[50] In comparison, CHC, AHAC and NPLC models of interprofessional primary care have a more egalitarian team structure, with a salaried funding model and community governance.[49] There are currently more than 70 CHCs (serving four per cent of Ontarians), 10 AHACs, and 25 NPLCs in Ontario.[51][52]

*Table 2 - Primary care models in Ontario*

| Models | Description | Leadership | Funding model |
|---|---|---|---|
| **Community Health Centre (CHC)** | Interprofessional teams providing comprehensive primary care. Strong community development focus that addresses the determinants of health. | Governed by community | Salary |
| **Aboriginal Health Access Centre (AHAC)** | Interprofessional teams providing comprehensive primary care. Modeled after CHCs with a focus on providing culturally relevant services to Indigenous communities both on- and off-reserve, across urban, rural, and northern locations. | Governed by community | Salary |
| **Nurse practitioner-led clinic (NPLC)** | NPs in collaboration with interprofessional teams providing comprehensive primary health care. | Governed by mix of community and NPs | Salary |
| **Community-Sponsored Family Health Team (FHT)** | Physician-led interprofessional teams providing comprehensive primary care. | Governed by mix of community and physicians | Blended salary |
| **Family Health Team (FHT)** | Physician groups affiliated with interprofessional teams providing comprehensive primary care. Practice types include Family Health Networks and Family Health Organizations. | Governed by physicians | Blended capitation (includes some fee-for-service and bonuses, premiums and special payments) |
| **Independent Practice** | Solo or groups of physicians (not associated with interprofessional teams) providing primary care. Practice types include solo physician practices, comprehensive care models, Family Health Group, Family Health Organizations, and Family Health Networks. | Governed by physicians | Mix of<br>• Fee-for-service<br>• Enhanced fee-for-service<br>• Capitation<br>• Bonuses, premiums and special payments |

Sources: 51 52 53 54

Interprofessional team-based models of primary health care must be expanded until all Ontarians have access. This is especially critical during this time of health-system reform. Expanding access to interprofessional teams can be achieved by increasing patient enrollment across existing models, and creating new sites where there is a need. There must also be a moratorium placed on the creation of new independent practice models in primary care.

The existing primary care providers who do not work in interprofessional team-based models must form new connections to team care. One example of work in this area is by the Alliance for Healthier Communities, through the Seamless Care Optimizing the Patient Experience (SCOPE) project. SCOPE creates access to team care where this does not already exist by establishing formal partnerships with PCPs, care co-ordinators and other health and non-health service partners in the community and hospital (e.g. specialists, home care and social work). **A nurse in a care co-ordination and navigation role acts as the centralized point of access for these connections between PCPs, patients and other stakeholders. This model could be scaled up to ensure 100 per cent of independent primary care providers in Ontario are linked with team care.**[48]

For Ontarians who do not want to align themselves with a PCP, a special access process can be developed to allow people to apply to the OHT directly. Through the OHT, they can be connected to a care co-ordinator who will establish what the person's needs are, and provide care accordingly, or alternatively direct people to a home or community care service provider. This is not unlike evolving developments in the province where certain people can access publicly funded personal support service directly through support service providers. However, Ontarians will be actively encouraged to join primary care organizations to promote the continuity, comprehensiveness and improved health outcomes associated with a consistent primary care provider and care co-ordinator.

Increasing access to interprofessional primary care teams that provide comprehensive and continuous care will better meet the needs of Ontarians during their first and ongoing interactions with the health system. This, in turn, will decrease the demand on other parts of the system, including unnecessary emergency department visits and the use of walk-in clinics. In fact, with full implementation of the ECCO model, walk-in clinics can be eliminated.

(4) **RECOMMENDATION 4: Comprehensive care co-ordination**

Make comprehensive care co-ordination, based in primary care, available to all Ontarians 24/7.

Action items:

- Locate the care co-ordination function in primary care.

- Transition all RN care co-ordinators currently employed by Ontario Health (previously Local Health Integration Networks (LHIN) to interprofessional primary care teams.

- Expand the care co-ordinator role to provide comprehensive and consistent service for all Ontarians.

- Support the work necessary to determine appropriate care co-ordinator case load to reach all Ontarians.

An essential component of the ECCO model is the primary care sector providing comprehensive care co-ordination and health system navigation for all Ontarians. The evidence demonstrates care co-ordination is a core function in high-performing primary care models. A dedicated care co-ordinator position is required as part of an interprofessional team.[53]

The overarching purpose of the care co-ordinator role is to:

- be a consistent contact for each Ontarian throughout their interactions across the health system,

- facilitate access to interprofessional and specialised care for patients,

- help patients and families navigate programs and services across the health system.

Primary care RNs must take a lead role in care co-ordination and system navigation in collaboration with other qualified professionals within the interprofessional team. The ECCO model urges the transition of the approximately 4,500 care co-ordinators currently employed within LHINs (and not performing hospital discharge functions) into interprofessional primary care teams, with their salary and benefits intact. (See transition recommendation 3 on pg. 52).

Primary care-based, RN-led care co-ordination for complex populations is well supported within the scientific literature.[54 55 56 57 58 59] **RN care co-ordinators can contribute their expertise and system knowledge by providing dedicated and comprehensive care co-ordination and health system navigation to Ontarians with the most complex needs.**

A focus on linking care co-ordinators with complex patients is a necessary place to start, and aligns with the current role of the care co-ordinator in providing services to persons with complex clinical and/or social needs. It is estimated that 20 per cent of patients at any given time require care co-ordination services.[48] In addition to the 4,500 RN care co-ordinators providing services to Ontarians with more complex needs, there are 1,882 NPs, 4,457 RNs and 4,566 RPNs in positions currently in primary care.[60] Along with the 4,500 RN care co-ordinators, these nurses can provide care within their scope of practice, to Ontarians with varying levels of complexity across the lifespan. Most Ontarians experience minimal interaction with the health system, and when care is required, it is typically for episodic illness. However, a strengthened primary care system will take every opportunity to see care co-ordinators delivering services with an emphasis on co-ordinating care for persons across the health continuum as needed, supporting persons to navigate the health system during transitions, and proactively engaging with persons about health promotion, disease prevention and chronic disease prevention and management.

Ensuring all persons with complex needs have access to a care co-ordinator is a starting point. From there, we need to ensure additional work is done as health-system reforms take shape. To fully realize the vision of ECCO, more research will help address the gaps in knowledge and develop robust evidence-informed recommendations on the appropriate case loads for care co-ordinators, and the total number of care co-ordinators necessary to achieve the end goal of 24/7 access to care co-ordination for all Ontarians. There is currently a wide range of care co-ordination case loads, sometimes as low as 40 when care co-ordinators are working with

people with high complexity, and sometimes up to 300 for co-ordinators working with persons who have less complex needs and/or their care needs are of shorter duration.[61] An analysis of population level health needs can inform the appropriate number of care co-ordinators required in Ontario, based on clinical and social complexity and resource utilization.

**The ECCO model further envisions an expanded role for care co-ordinators, incorporating a more upstream and comprehensive approach.** In LHINs, the role of care co-ordinators was to determine eligibility and ensure access to a limited 'basket' of home and community care services. Co-ordinators would assess needs, determine the care plan, arrange services, review the care plan, and determine long-term care placement.[62] In the ECCO model, the care co-ordinator role is more comprehensive, and leverages the expertise of home health care and support service providers.[29]

**The role of the care co-ordinator**

- ECCO envisions the care co-ordinator will take a comprehensive approach to providing service by:

- attaching all persons within an OHT boundary to primary care,

- building and maintaining relationships with all individuals to understand and advocate for their needs,

- serving as the vital link between the person, primary care provider, interprofessional team and specialty care practices,

- conducting annual comprehensive assessments using a whole person approach that encompasses an evaluation of determinants of health,

- developing a comprehensive and co-ordinated person-centred care management plan utilizing the strengths of the interprofessional team,

- managing primary care needs in collaboration with interprofessional teams, including facilitating same-day access to services,

- activating, organizing and navigating all health and social services within the community and in institutions across the lifespan,

- connecting persons to additional community and social services (e.g. housing),

- supporting safe and timely transitions from one care setting to another (e.g. from hospital to home in collaboration with the hospital discharge planner),

- partnering with individuals and families to identify and secure optimal residential care placements in co-ordination with Ontario Health (which leads the overall placement system, i.e. waitlists, vacancies, etc),

- assessing and monitoring health status and well-being, with ongoing evaluation of effectiveness of interventions.

Within the current health system, there are specialized care co-ordinators outside of LHINs who focus on providing dedicated support to clients concerning cancer, mental health, pediatrics and gerontological support. These providers work with clients for varying lengths of time, from weeks to years. The ECCO model advises the retention and strengthening of this role through a close, ongoing connection with the care co-ordinator in primary care. Upon completion of the specialized relationship, the client transitions back to the primary care co-ordinator to ensure continued access to care co-ordination and system navigation across the lifespan.

ECCO recommends educational and training programs targeted towards care co-ordinators to refine and enhance care co-ordination and system navigation competencies. This can be accomplished by leveraging the extensive education capacity that currently exists within the health system. For example, RNAO's week-long Primary Care Nurse Institute in 2013 utilized an expert faculty and a robust curriculum to support full scope of practice utilization of primary care nurses. An entire component of the curriculum was devoted to enhancing care co-ordination and system navigation, which received excellent feedback. A similar program could be utilized in the future.

( 5 )    **RECOMMENDATION 5: Enhanced community care across the continuum**

Enhance all community care services across the continuum of care.

Action items:

- Augment the capacity of primary care to address mental health and addiction.

- Invest in improving the availability and quality of community based mental health and addiction services.

- Ensure robust home and community care services.

- Transition the responsibility for home-care services directly to home-care agencies.

- Reform the home-care funding model from a per-visit basis to funding baskets to allow a person-centred approach that encompasses a range of nursing interventions, including health promotion and ensuring continuity of care and continuity of caregiver.

- Ensure home-care contracts are awarded to providers that are able to deliver a broad range of services around the clock, so as to avoid fragmented care.

- Optimize the health system to better connect people to the range of social services necessary for health and well-being.

Building on a strengthened primary care foundation, there must also be robust community care. The ECCO model envisions an enhanced and integrated community care sector that seamlessly transitions from primary care to the range of services and supports across the continuum of care. This includes strengthened mental health and addiction services, comprehensive home and community care services, and seamless connections to social services. **31**

**Mental health and addiction services**

> Mental health and addiction services include a wide variety of providers, programs and services that span mental health promotion and mental illness and addiction treatment. Mental health and addiction services take place through primary and community care, specialty offices and agencies, and hospitals.

The ECCO model requires increased efforts dedicated to ensuring mental health and addiction services are strengthened and better integrated across the continuum of care, starting in primary care. This involves first enhancing the capacity of primary care providers to address mental health and addiction. The capacity of these providers must be built to ensure the following are part of routine care: mental health promotion, mental health and addiction assessments, brief interventions and referrals. **This will increase mental health promotion and early intervention, improve access to mental health services (especially in rural areas), and help reduce stigma associated with mental health issues.**

Alongside a strengthened primary care sector, there remains the need for specialized mental health and addiction services in the community. These services include (but are not limited to): assertive community treatment, intensive case management, home detoxification services, recovery homes, and consumption and treatment services. Strengthening mental health and addiction services in the community should start by transitioning mental health and addiction nurses currently in LHINs to interprofessional primary care teams and to child and youth mental health agencies.[63] This will better connect and integrate services for children, youth and families struggling with mental health issues. Further investments are also needed to address the long wait times and gaps in capacity in mental health treatment. This requires hiring more front-line professionals to ensure Ontarians can get the help they need, where they need it, and in a timely manner.

**Home and community care services**

> Home care includes a range of health and social services for people of all ages in the home, workplace, school and other community settings. Services span nursing, personal support and homemaking, therapy (including physiotherapy, occupational therapy, speech language pathology, social work, nutrition), and medical supplies and equipment in the home.

> Community care services are additional health and social programs that enable individuals coping with health and/or social issues to live safely and comfortably in their own homes. These support services include:

- Personal support services and assisted living.

- Meals and help around the house.

- Day activities (e.g. adult day services, rides and transportation, security checks).

- Caregiver support.

- Condition-specific services (e.g. Alzheimer or dementia services; acquired brain injury services, vision impaired care services; deaf, deafened and hard of hearing care services).

- Hospice and palliative care services.

Comprehensive home care encompasses health education and teaching, treatment, rehabilitation, health maintenance, social adaptation and integration, support for the family caregiver, and end-of-life and palliative care.[64] These services and supports help frail people or those with acute, chronic, palliative or rehabilitative health-care needs to independently live in their community. Such services are also needed to co-ordinate and manage admission to a care facility when living in the community is no longer an option. Access to home care also enables patients in alternative level of care beds to leave the hospital sooner.

> "Let's look at making a total paradigm shift and focusing all our services, programs, everything we need on helping and maintaining people to stay in their home of their choice"
>
> – Dr. Suzanne Brake, Seniors' Advocate, CBC News, May 1, 2020[65]

ECCO demands comprehensive home-care services and supports that are accessible, equitable, person-centred, integrated and publicly funded. In the context of health-system reforms, this means OHTs will award contracts to home and community care organizations based on quality outcomes and accountability, according to these attributes. For example, home health-care providers must be required to offer a range of accessible services that are person-centred and promote continuity, avoiding fragmented care across different agencies. **OHTs must ensure funding follows the person in an efficient and person-centred manner, adjusting for personal characteristics**. This includes a funding model that moves away from payment on a per-visit basis to funding baskets that follow evidence-based pathways and leverage provider knowledge and autonomy. In addition, the funding model must be stabilized to enable a greater proportion of full-time nursing employment within the sector. As a result of these changes, the role of the home-care nurse will evolve from a task-based care model to one that is more person-centred and encompasses a range of nursing interventions, including health promotion strategies. This means an emphasis on continuity of care and continuity of caregiver by assigning each person a primary nurse. The principle nurse should work to their full scope of practice and be accountable for delivering the total nursing care required by the client.

Within the ECCO model, care co-ordinators will make the initial referral for home-care services, and then the home health-care organization will develop, monitor and refine a personalized care plan for the client while maintaining information sharing with primary care. Once home health-care services are discontinued, a discharge summary will be sent to the care co-ordinator. The ECCO model also sees an opportunity to introduce advanced practice nurses, such as clinical nurse specialists and nurse practitioners, to the home-care sector. Research validates the influence clinical nurse specialists have on promoting positive client outcomes in the

home, as well as on the effectiveness of the nurse practitioner role in the home-care setting.[66] [67 68 69 70] Areas where advanced practice nurses can excel in the home environment include (but are not limited to): chronic disease prevention and management, pain management, wound care, palliation and care of older adults. Coupled with a steady supply of home-care RNs, and a relationship with primary care, advanced practice nurses can minimize the need for physician house calls, enabling physicians to focus their expertise elsewhere within the system.

> "Care in the home is critically important, esp.[ecially] during this pandemic. Unmet home care needs will quickly escalate, leading to family caregiver burnout and pressure in other areas of the system. Let's leverage vs limit the home as a SAFE setting for care"
>
> – Shirlee Sharkey, President & CEO SE Health, April 21, 2020[71]

The home-care sector, as envisioned under the ECCO model, places a focus on service priorities through collaboration with the other health sectors, service co-ordination, and full scope of practice utilization. This means home-care services are more robust and can increase as savings from administrative and operating costs (with health system restructuring) are re-invested into front-line care.

## Social services

> Social services are the range of public services that promote the welfare of communities. Beyond health care, these services include benefits and facilities for education, income support, job training, housing and food assistance.

The ECCO model demands the health system reach beyond what is typically considered health-care services to also include stronger connections with the range of social services necessary for good health. A strengthened primary care sector that includes the care co-ordinator position is critical to fostering these connections. This is built on an understanding of health equity, and takes into account the determinants of health beyond the health system, including social factors that shape health, such as income, employment, education and housing. **Investing in social services and improving the co-ordination between health and social services is crucial to creating a healthier Ontario and to reducing health system costs.** Social services, such as affordable housing, income support and nutritional assistance, are especially important for certain populations, including low-income individuals, the elderly and those with disabilities.[72] A 2016 literature review on the impact of investments in social services found that 100 per cent of income support programs, 88 per cent of care co-ordination and community outreach interventions, 83 per cent of housing support programs, and 64 per cent of nutritional support programs had positive effects on health outcomes, health-care spending, or both.[73]

Re-imagine long-term care (LTC) as 'home' to residents, and integrate nursing and retirement homes into enhanced community care plans and funding.

Action items:

- Require that all OHTs incorporate LTC as part of their team configuration, such that all LTCs are actively connected to the full health system.

- Incorporate a focus on the person-first philosophy, planning care and services according to the person's individual needs and wishes rather than those of the medical care model.

- Modernize the funding formula in LTC – immediately – to account for complexity of care needs and quality outcomes.[8][9]

- Modernize staffing in nursing homes immediately.[8][9]

- Develop new and renovated nursing homes for persons with dementia, with special consideration to smaller congregates of up to seven residents per house, and with design based on resident preferences.

  - Example: De Hogeweyk – A gated model village in Weesp, Netherlands, which already exists in Canada's first community designed specifically for people with dementia in Langley, British Columbia.[10][11][12]

The focus of ECCO 3.0 is on enhancing community care, and we conceptualize long-term care facilities as the homes of their residents. We cannot ignore this sector in our effort to reshape care facilities in the community.[74] **Embracing the LTC sector as part of community care enables us to move away from the medical model that permeates care delivery.** The recommendations related to the LTC sector help ensure person-centred care, community based approaches and increased accessibility.

These are key requirements to address the harm our seniors have experienced during the COVID-19 pandemic. The devastating impact of the pandemic on LTC residents is a direct result of policy and political flaws in our health system that have, for decades, sidelined the LTC sector and left it neglected in government funding and in health transformation plans. Even in the newly developed OHTs, there is no mandate to include LTC homes and retirement homes as part of the team configuration to enable full integration.[117]

> "#COVID19- Kingston, Frontenac and Lennox & Addington PHU @KFLAPH:
>
> #LTC cases: 0
>
> Hospitalized: 0
>
> In ICU: 0
>
> On ventilators: 0"
>
> – Dr. Iacovos Michael, May 5, 2020[75]

> "And, in #Kingston they implemented #universalmasking and extensive #testing in all their nursing homes ahead of most! BRAVO to the whole team!"
>
> – Dr. Doris Grinspun, CEO RNAO, May 5, 2020[76]

RNAO is engaged in in-depth work on a renewed vision for LTC that incorporates our collective experiences during COVID 19. The results of this work will soon be released, and will offer an innovative model for reshaping this vital community component of care. It incorporates LTC homes and retirement homes as full partners in OHTs, and includes this sector in the health-care transformation agenda. We address key elements of funding, staffing and care delivery with full attention to the horrific experiences the LTC sector has endured during the COVID-19 pandemic. RNAO's vision for LTC will offer a brighter future for Ontario seniors in need of these health services.

**(7) RECOMMENDATION 7: Evidence-based practice**

Demonstrate a commitment to evidence-based practice across the health system.

Action items:

- Support staff engagement in the implementation of evidence-based practice.
- Use best practice guidelines (BPG) to inform care delivery.
- Enable integrated and person-centred care through the use of RNAO BPGs.
- Monitor and evaluate the impact of the implementation of evidence-based practice.
- Reinvest all savings from improved outcomes in direct care.

Consistent with Ontario's health-system transformation and the mandate of OHTs, the ECCO model promotes the use of evidence to guide decision-making and care delivery across the

health system. **Evidence-based practice is central to achieving the Quadruple Aim of improved patient experience, improved patient outcomes, lower cost of care, and improved provider experience.** Evidence-based practice will serve us well in advancing a high-quality integrated system of care for all Ontarians and positioning our province as a top performer.

ECCO envisions the local level taking on the important role within OHTs of leading the creation of an evidence-based practice culture. Significant local resources, supports and best practices are available to health organizations to make this happen. A key resource is RNAO's Best Practice Guidelines (BPG) program, with more than 54 published BPGs available electronically at no cost.[77] These evidence-based tools cover a range of clinical and healthy workplace topics. The guidelines focus on evidence to enable positive patient, organizational and health-system outcomes across all sectors and settings.[78] RNAO recognizes and values the important role nurses, other health professionals, and persons with lived experience have played and continue to play in the development and implementation of evidence-based practices to promote and sustain improvements in health and well-being across the health system.[68]

To further propel evidence-based practice, RNAO has an organization-level implementation program: the Best Practice Spotlight Organization (BPSO).[79] [80] **The BPSO program supports the uptake and sustainability of evidence-based practice across health organizations through the full engagement of interprofessional staff and persons with lived experience in the implementation of BPGs.** More than 1,000 health organizations have formal agreements with RNAO as active BPSOs. Six hundred are in Ontario and the remaining 400 span across the rest of Canada and abroad, funded by their local governments.[79] [80]

In line with the vision of ECCO, and in the context of Ontario's health-system transformation, RNAO created a new BPSO model specific to OHTs.[81] This model is intended for integrated systems of care in which all the organizations that form an OHT implement BPGs as one co-ordinated team with support from RNAO. All BPSO OHTs implement the *Person- and Family-Centred Care* (2017) and *Care Transitions* (2020) BPGs to promote and enable the key attributes of an integrated and person-centred system. BPSO OHTs also select two or more additional BPGs to collectively advance their clinical priorities. RNAO actively supports all BPSOs free of charge, and remains inspired by the outcomes.[82]

The implementation of evidence-based practice at the local level must also inform the ongoing measurement and evaluation of the performance of the health system, both at the local level and overall. The ECCO model supports developing systematic measures to monitor and evaluate the impact of the health reforms to create a more accessible, equitable, person-centred and integrated system that delivers better outcomes that are in line with the government's Quadruple Aim of improving patient and caregiver experience, improving population health, reducing unit health care costs, and improving the work life of providers.[83]

Within RNAO's BPSO model, this work is supported through RNAO's Nursing Quality Indicators for Reporting and Evaluation (NQuIRE) database. NQuIRE collects, analyzes and reports comparative data on nursing-sensitive indicators reflecting the structure, process and outcomes of care arising from BPG implementation.[84] [85] **With increasing emphasis on quality improvement, nurses have a tremendous opportunity to assume leadership in collecting and interpreting quality improvement data, scaling up improvements, and addressing outcome shortfalls.** NQuIRE serves all BPSOs, including OHTs, to advance health-system performance and is supported by one of the strongest international advisories anywhere in Canada.[86]

## 8 · RECOMMENDATION 8: Optimized digital health

Optimize digital health technologies to improve access, enhance integration and support person-centred care.

Action items:

- Establish a standardized and shared system for collecting data and disseminating population health information across the system.

- Develop and maintain a province-wide strategy to make electronic personal health records available to all Ontarians based on the principles of accessibility, security, comprehensiveness, patient-control, and publicly-funded and administered.

ECCO seeks to optimize the potential of digital health technologies to improve access and integration across the health system, to support person-centred care, and to increase system efficiency. Digital health is an umbrella term for information and communications technologies as well as emerging trends in advanced computing sciences such as big data, genomics and artificial intelligence.[87] While there is potential for digital health to be used to improve the key attributes of the ECCO model, such technological interventions must be evaluated on their ability to meet these aims while protecting privacy and confidentiality, and ensuring necessary non-digital approaches to health care remain sufficiently resourced.

**When digital health technologies are used to improve access to population health data and personal health information, they can support better integration and collaboration among care providers and patients.** At the system level, the collection and shared use of population health data should inform decisions and ensure accountability. ECCO supports a standardized and shared system for collecting data and disseminating population health information across the system. For example, primary care, public health and acute care can leverage the data obtained by the other to support their respective functions more effectively. Primary care generates data that can be used to create a local population database, while the data from public health can be used to determine the risks in the community, and allow care providers to tailor their work to specific needs.[88] RNAO's BPG Order Sets are an example of how digital health and evidence-based practice can be used together across the continuum of care to make it easier to provide clear, concise and actionable interventions that can be readily incorporated into various practice settings, such as hospitals, LTC and in the community.[89]

**Types of electronic health records**

> **Electronic medical record (EMR):** A digital version of a paper chart that contains a patient's medical and clinical data gathered from one provider organization (e.g. physician's office, FHT). It is not easily shared with providers outside of that organization.
>
> **Electronic health record (EHR):** A digital version of longitudinal systematic records of clinically relevant information, created from information drawn from multiple data sources. It can be shared across different health-care settings.
>
> **Electronic personal health record (PHR):** A digital health record controlled by patients that can integrate information from a variety of sources. This is a resource that patients can securely store to monitor their own health information.

At the individual level, PHRs are an important tool to easily access and safely share health information, by both providers and patients. This has clear benefits for access and integration, as well for person-centred care.

PHRs allow people to access and store their own health information, feel better supported to manage their own health and health care, and more efficiently and safely share health information among providers, which facilitates communication between patients and providers.[90] **Evidence shows that PHRs help people make informed decisions and become active partners in their health care.**[91] And if they have access to their health information, they are more satisfied, informed and engaged in their care.[92] [93]

Tethered PHRs are a type of integrated record linked to a specific provider's EMR system. The majority of information in the tethered PHR is automatically drawn directly from the primary care provider's existing EMR. Patients can access and add to their records through a patient-facing, web-based portal.[94] [95] ECCO recommends tethered PHRs that can link to providers EMR systems, interface with existing data repositories, and provide a comprehensive set of health information.

To further inform recommendations related to the impact of digital health technologies on health-care delivery, RNAO is currently in the process of conducting a scoping review on the topic of 'Nursing in the Age of Artificial Intelligence'.[96] This scoping review – to be completed in 2020 – will cover emerging trends in digital health technologies that are likely to impact the role and function of nurses over the next five to 10 years, and the implications of these trends on all domains of nursing practice, as well as the opportunities and barriers for nurses.

> Maximize and enable the full scope of practice of all regulated health professionals.
>
> Action items:
>
> - Implement legislative and regulatory changes to maximize appropriate and safe scope for regulated health professionals.
>
> - Remove organizational barriers that prevent regulated health professionals from working to their full, legislated scope of practice.
>
> - Provide resources to enable regulated health professionals to enhance their individual knowledge, skill and judgment and develop competency in their full scope.

A workforce in which nurses and all regulated health professionals can work to their full scope of practice will facilitate timely access to care, better meet the comprehensive needs of Ontarians, and improve system efficiency.

Nurses represent the largest group of health professionals in the province. RNs are autonomous and work in all practice settings. **With more than 100,000 RNs registered to practise with the College of Nurses of Ontario,[97] ensuring RNs are able to work to a full, expanded scope will improve access to care, continuity of care, patient satisfaction, and health outcomes while making the most effective use of health-care resources.**[98]

Following an evolving nursing role and scope in other countries, it is anticipated that RN scope of practice will soon be expanded to authorize RN prescribing for non-complex health conditions. RNAO has been calling for independent RN prescribing since 2012, to improve timely access to care.[99] [100] [101] Clearly these changes in legislation related to expanded scope take too long, despite solid evidence, implementation plans and professional and stakeholder support.



*Neonatal Intensive Care nurses, Shaunna Neilson and Olivia Kavanagh, SickKids Hospital*    **40**

## RNAO's history of advocacy for RN prescribing[101]

**2012**
RNAO convenes Primary Care Nursing Task Force, which releases *Primary Solutions for Primary Care* report and recommends expanding scope of practice for RNs to include prescribing.

**2013**
At RNAO's 88th Annual General Meeting, Kathleen Wynne (then premier) commits to expanding RN scope of practice to include prescribing.

**2015**
Eric Hoskins (then health minister) announces launch of consultations. The health ministry requests Health Professionals regulatory Advisory Council (HPRAC) advise on RN prescribing.

**2016**
RNAO provides feedback to HPRAC which presents its report to the ministry on RN prescribing with recommendation for a model of independent RN prescribing. RNAO's *Mind the safety gap in health system transformation* is released, advocating for independent RN prescribing.

**2017**
*Stronger, Healthier Ontario Act, 2017* amends *Nursing Act, 1991* to authorize RNs to prescribe medications and communicate a diagnosis, NOT order and perform diagnostic tests. The ministry directs the College of Nurses of Ontario (CNO) to develop necessary regulation to enable RN prescribing.

**2018**
RNAO participates in CNO roundtable discussion and provides feedback on RN prescribing competencies. CNO circulates draft regulations for consultation.

**2019**
RNAO provides a submission in response to government's proposed regulatory amendments, calling for an expanded scope of practice that enables independent RN prescribing in all practice settings and is inclusive of diagnostics.

**2020**
RNAO advocates at the ministry level for the creation of RN prescribing curriculum to be expedited. RNAO continues to advocate for expanded RN prescribing, inclusive of diagnostics.

Independent RN prescribing has been in place for over a decade in the United Kingdom and many other countries.[102] Since RNs are often a person's first point of contact with the heath system, scope expansion allows RNs to better respond to patients. The recent legislative and regulatory amendments are an important first step, but more can and must be done to realize the full potential of independent RN prescribing. Next steps for expanding RN scope with respect to prescribing include removing the restriction of drug lists and including access to diagnostic testing.

Further to this important scope expansion, RNs must be fully optimized to work to their full scope in all sectors and practice settings. Currently, this is not the case for many RNs. There are persistent barriers in the form of policy (e.g. in hospitals) and organizational practices (e.g. in primary care) that restrict the role and practice of RNs. In primary care, there is significant untapped potential for RNs to better serve populations by consistently working to their full scope.

**The Greater Peterborough Family Health Team (GPFHT) provides one example of work being done to remedy this issue. The interprofessional team at GPFHT introduced a full scope RN role, providing an opportunity for RNs to apply their comprehensive knowledge, skills and competencies in practice. Through this work, GPFHT increased the range of services offered through existing human resources, which improved access to care and reduced its older adult populations' non-urgent emergency department visits by 20 per cent.[103] Other primary care organizations can learn from this model.**

NPs also face significant barriers working to their full scope of practice. NPs are registered nurses who have additional education and experience in which they develop advanced competencies to work within a broader scope of practice. Evidence collected over the last 40 years shows the positive value and impact NPs have on patient care and health system outcomes.[104] [105 106 107] Despite this evidence and the fact that Ontario has been a trailblazer in developing and expanding the NP role, persistent barriers hinder NPs from working to their full scope and providing the continuum of care to patients.

For example, NPs have the legislative authority to act as the most responsible provider (MRP). This means they are the health-care provider with primary responsibility and accountability for a person across their care trajectory. Yet many NPs are not practising in the MRP role at the discretion of their organization. It is highly variable by sector and by organization whether an NP is working as the MRP, with primary care having the majority of NPs in the MRP role while hospitals only have minimal examples across select organizations.

In addition to organizational barriers, there are also unnecessary legislative and regulatory barriers to NP scope, such as the authority to initiate legal forms for mental health services. RNAO has a long history of advocating for NP scope expansion that aligns with the evolution of the health system and the NP role. This would further support ECCO's vision of improved access.[108]

Policies and practices that limit scope are not limited to nurses. Many regulated health professionals are underutilized in our health system. The ECCO model proposes enhancing and fully utilizing all regulated health professionals to better meet the needs of Ontarians, starting in the community. This includes pharmacists and midwives. Pharmacy services in Ontario include a range of services, such as medication review and education, filling prescriptions, adapting and renewing prescriptions, prescribing certain drugs (e.g. smoking cessation), administering certain drugs (e.g. influenza vaccine), and performing certain procedures (e.g. blood glucose testing).[109] Expanding the role of pharmacy services to better meet the needs of Ontarians in the community has the potential to enhance person-centred care and improve access to health-care services.

Midwifery services encompass 24/7 on-call care for women and their families throughout normal pregnancy, birth and the first six weeks after birth. The midwifery model of care aligns with ECCO in that it is person-centred and grounded in the community. Ontario must increase investments in midwifery care to meet the demand for care, and remove barriers that prevent midwives from practising to their full scope.[110] The underutilization of midwives creates inefficiencies such as unnecessary transfers of care and physician consultation. Indigenous midwives, in particular, play an important role in serving Indigenous communities, including in rural, remote and northern areas. Indigenous midwives from these communities need training and support to stay in their communities to provide perinatal care.[111]



*Jasmin Tecson,*
*Association of*
*Ontario Midwives*
*(AOM) President*

# HEALTH SYSTEM TRANSITION

RNAO provided government and stakeholders with a bold health-system transformation plan – ECCO 1.0 – in October 2012.[6] It clearly outlined critical functions that were essential for a successful and fully functional health-care system that is accessible, equitable, person-centred, integrated and publicly funded. These signature values were presented again in ECCO 2.0 in 2014.[7] And now, ECCO 3.0 further demonstrates how these critical functions are paramount to the transformation goals and the ECCO model. These functions are presented again in the chart below with a status update indicating a snapshot of where we are, and imperatives for action.

*Table 3*

| Function | Leader | Transition Timeline | Progress to Date |
|---|---|---|---|
| Creation of a Primary Care Secretariat (Transitional) | Local Health Integration Networks | December 31, 2012 | No action. |
| Regional health system planning | Local Health Integration Networks | December 31, 2012 | Transferred to Ontario Health and OHTs. In progress. |
| Establish geographic primary care networks | Local Health Integration Networks and primary care organizations | December 31, 2012 | OHTs. Partially adopted. |
| No more new solo practice family physician models | Ministry of Health and Long-Term Care | December 31, 2012 | No action. |
| Initiate labour management strategy as part of ECCO | Unions, community care access centres and Local Health Integration Networks | December 31, 2012 | No action. |
| Contract management with providers | Local Health Integration Networks | December 31, 2013 | Transferred to OHTs. In progress. |
| Creation of patient/family councils | Local Health Integration Networks | December 31, 2013 | OHTs. Partially adopted. |
| Rapid response nurses | Home health-care providers | December 31, 2013 | Fully adopted. |
| Nurse practitioner integrated palliative care program | Home health-care providers | December 31, 2013 | No action. |
| Health Care Connect | Primary care organizations | December 31, 2013 | Fully adopted. |
| Mental health and addiction nurses in district school boards | Public health units (RNs) and mental health programs (RPNs) | December 31, 2013 | Partially adopted. |
| Expanded community laboratory services | Community laboratories | December 31, 2013 | Partially adopted. |
| Quality and performance management | Local Health Integration Networks | December 31, 2014 | Transferred to OHTs. In progress. |
| Completion of a Primary Care Secretariat (Transitional) | Local Health Integration Networks | December 31, 2015 | No action. |
| IT infrastructure/Client Health and Related Information System (CHRIS) | Local Health Integration Networks and primary care organizations | December 31, 2015 | Transferred to OHTs. Partially adopted. |
| Long-term care home placement | Local Health Integration Networks and primary care organizations | December 31, 2015 | Partially adopted. Done by CCACs, then LHINs. RNAO recommends it be done by OHTs. |

| Function | Leader | Transition Timeline | Progress to Date |
|---|---|---|---|
| Comprehensive care co-ordination | Primary care organizations | December 31, 2015 | Minimal action. Most of Ontario's 4,500 care co-ordinators remain with Ontario Health. RNAO recommends transfer to OHTs and primary care. |
| Discharge planning | Primary care organizations and hospitals | December 31, 2015 | Action pending. |
| Ordering home-care services | Primary care organizations | December 31, 2015 | No action. |
| System navigation | Primary care organizations | December 31, 2015 | Partially adopted. OHTs eventually. |
| Completion of legislative/regulatory RN scope of practice enhancements | Primary care organizations | December 31, 2015 | In progress. |
| Complete labour management strategy | Unions and Local Health Integration Networks | December 31, 2015 | No action. |
| Transition all current solo family practice physicians to groups | Ministry of Health and Long-Term Care | December 31, 2015 | Partially adopted. |
| Elimination of walk-in clinics | Ministry of Health and Long-Term Care | December 31, 2015 | No action. |
| Public health units under LHIN mandate | Local Health Integration Networks and 36 public health units | December 31, 2015 | No action. |
| All Ontarians receiving care within a CHC, NPLC, AHAC or FHT | Primary care organizations | December 31, 2020 | Partially adopted. |
| Delivering home-health care | Home health-care providers | Ongoing | Partially adopted. |

The ECCO model provides government and stakeholders with a bold vision for Ontario's health system. In the context of the current reforms, the transition recommendations that follow will provide critical direction and actions to guide the transformation to an accessible, equitable, person-centred, integrated and publicly-funded system in a timely way.

**(1)** **TRANSITION RECOMMENDATION 1: Lead with primary care**

Include primary care in a leadership role in the process of transforming the health system.

Action Items:

- Embed primary care leadership into the OHT application process and ongoing performance management.

- Establish the Ontario Primary Care Council as a regional primary care advisory table.

- Re-locate the ministry of health's primary care branch to Ontario Health.

- Maintain strong focus on primary care at the ministry of health.

**Primary care must have an active presence at all levels of health-system leadership and governance for the sector to be enabled as the foundation of the system.** It must be based on a collaborative leadership approach that includes leaders with diverse skills and expertise in multiple health sectors, and with an emphasis on having a strong primary care voice at the table. Leaders must be able to bridge sectors and disciplines to reduce fragmentation and promote continuity of care while ensuring collaboration with primary care as the foundation of the system.[111] There is also an opportunity for nurses to be involved and serve in leadership positions in health-system reforms. In addition to making up the largest segment of the health workforce, nurses bring diverse and unique perspectives and expertise from roles across health sectors, including providing front-line care, acting as care co-ordinators, and through formal leadership roles such as chief nursing executives.

The ECCO model, building on engaged and collaborative leadership, identifies three levels of health-system governance – community, regional and provincial – in which primary care must be engaged.

- **Community** – The operation and governance of health care at the community level will be provided by OHTs. Primary care must play a foundational role in OHTs by having a seat at leadership and decision-making tables, being an active partner in planning and service delivery, and by taking on the role of co-ordinating care across sectors. This can start by supporting communities with established interprofessional primary

care models – such as community health centres and nurse practitioner led clinics – to take on a leadership role within their OHTs, and by including all primary care settings within a geographic area in the team. Ontario's primary care settings are ready and willing to take on this important function with the support of the health ministry, Ontario Health and the Ontario Primary Care Council.

- **Regional** – Regional governance will be provided by Ontario Health, including its five regional offices, and is responsible for system planning, funding and accountability. The Ontario Primary Care Council, founded by key stakeholder associations relevant to primary care [36], can take on a leadership role at this governance level to advise and support the work necessary to advance and strengthen primary care as the foundation of the health system. The Primary Care Branch of the Ministry of Health should be transitioned to Ontario Health to further support this work.

- **Provincial** – Provincial governance is offered by the Ministry of Health in its role as broad system planner and steward of Ontario's health system. A focus on primary care at this level will ensure the sector is supported in its foundational role.

## 2  TRANSITION RECOMMENDATION 2: Align funding with Quadruple Aim

Use a funding model for OHTs that drives them to realize the Quadruple Aim.

Action Items:

- Provide adequate funding for health care.

- Structure health-system funding to meet the objective that, by 2022, all Ontarians receive care through OHTs.

- Design all funding and compensation schemes to promote:

  o the Quadruple Aim (improved patient experience, improved patient outcomes, lower cost of care, and improved provider experience),

  o the delivery of all necessary health services,

  o the realization of a health system rooted in interprofessional primary care,

  o the development of a totally integrated health system with multidisciplinary teams that fully utilize the education and training of all health-care providers.

- Incorporate risk-based capitation and ensure it is evidence-based and experience-informed, and incents inclusion of all Ontarians – including vulnerable populations – in OHTs. That means risk-adjusting for social determinants of health like income and core housing needs.

- Supplement risk-based capitation with bundled-care funding that is evi-

dence-based and experience-informed and used appropriately: there must be clear clinical pathways and the funding must incent full and consistent care throughout health episodes.

- Preserve funding levels through return-of-savings to front-line health-care services.

- Ban fee-for-service billing direct to the ministry of health that would incent an expansion of fee-for-service physician-based primary care services.

- Incent participation of social-service providers, such as housing, in OHTs.

- Structure the OHT-funding models such that they strengthen the public, not-for-profit nature of Ontario's health system.

- Continue with professional, arm's length attribution of residents to the most appropriate OHT, reflecting resident choice of primary care provider.

Ontario is embarking on a radical reworking of its health system, including how health care is funded. As with all major change, there are potential advantages and disadvantages to these changes. It makes sense to seek an optimal trade-off among risks and rewards.

The province has signalled that it will move away from historical global funding that typified hospital funding. It intends to move to a blended prospective funding model for OHTs, mainly relying on risk-adjusted annual payments per enrolled patient – a form of capitation. The payments will be supplemented by activity-based funding (also known as bundled care) for specified episodic conditions. The province would continue to pay for other selected low-volume, high-cost procedures. [112]

1. Build risk mitigation into a prospective funding model

A prospective funding model – particularly one introduced in the context of significant system reform – encourages provider efforts to mitigate risk in the form of rationalization of service and the exclusion of high-cost populations. Risk-adjusted, population-based funding is an alternative form of risk mitigation. Married to a prospective funding model, it won't entirely relieve provider concerns. However, a risk-adjusted, population-based funding model better aligns funding with actual need than simple historical funding, which penalizes hospitals with growing populations. It will be important to risk adjust not just for age and gender, but also for other determinants of health, like income and housing, in order to assure equity of access.

Bundled payments are another form of risk mitigation in a prospectively funded system. Bundled payments cover complete episodes of care (e.g., cardiovascular surgery, plus follow up) to encourage proper treatment over the full episode and to discourage, for example, prematurely discharging clients to save money and thus transferring the burden onto other providers or the clients themselves. Ironically, premature discharge often results in early re-hospitalization at the very facility that prematurely discharged the patient. Bundled payments were introduced, in part, to discourage just such practices.[113] They work best with higher volume procedures that have clear clinical pathways,[114] so their use must be very selective, and it will be important to get the prices right to avoid gaming of the system by cost-sensitive providers. Careful assessments must be made of the costs and benefits of implementing bundled payments.

**RNAO recommends that both risk-adjusted population funding and bundled care funding be evidence-based.** However, it is critically important that these funding models also be informed by experience in advance of fixing formulas and establishing OHT funding benchmarks. Such a risk-free transition period will be important to ensure that providers are inclusive of their patient populations, and that real costs per OHT are established at the outset of system implementation.

Other means of risk mitigation ought to complement the funding model to ensure equity and access of vulnerable populations to health services. RNAO is pleased to note that, presently, a third party, the Institute for Clinical and Evaluative Studies (ICES), is engaged in the attribution of patient populations to OHTs based on the usual primary care provider.[115] This has the advantage of respecting patient-care provider choice and reducing cherry-picking opportunities for OHTs. If the ministry has an effective and rigorous process to implement this patient attribution and ensure its comprehensiveness, it will go a long way towards full coverage and aligning incentives with care objectives.

2. Ensure adequate funding

The government plans to implement a "shared savings incentive structure" that would allow an OHT to keep some of the savings if it were to meet quality expectations while keeping cost below a benchmark level.

The OHT guidance document doesn't explicitly say what failure to meet the cost benchmark would mean, but it could imply financial penalties for the OHT.[116] This is potentially the riskiest element in the province's OHT funding proposal. If cost benchmarks are set too low, then the temptation for OHTs will be to either reduce services or cut corners in areas of care that are not being measured, or that are hard to observe externally. If these benchmarks are set to health sector norms, they could also trigger destructive cost competition among providers, even in the absence of cost cutting mandated by the government. It could breed private-sector-type behaviour among government health agencies. That is not compatible with optimal patient care or cost-effective care.

While sustainability demands reasonable efficiency, we must be wary of cost control being the guiding principle. As the fiscal capacity section points out, Ontario already spends less on health care by national standards, and it is not clear how much fat or redundancy exists in the system. **As the Ontario Hospital Association points out, the province's hospitals rank as the most efficient in Canada, yet the hospital system is under significant financial pressure.**[117] The risk is that efficiencies result in spreading staff over more patients.

There is a risk that an internal market in health care, through the above benchmarking competition process, could readily facilitate actual privatization of health care, particularly during a period of rapid structural change, as provider organizations seek novel ways to cut costs or generate revenue. Critics warn that privatization of payment will end up in a two-tier system, with more and quicker care for those who can afford it,[118] as happened in Australia when the option emerged: more privatization meant longer waits in the public sector.[119]

More generally, any rapid restructuring also presents the opportunity for private providers and for-profit entities to create space for themselves. Research suggests that for-profit health care is more costly and delivers poorer outcomes.[40] There is also likely to be a lot of infrastructure built under this restructuring, and that will likely follow the costly Public-Private Partnership (P3) pattern in Ontario. In its 2014 annual report, the Auditor General of Ontario noted

that estimated cost to the province of 74 P3 projects was almost $8 billion higher than the estimated cost if it had been done publicly.[120] **Fraying of our public, not-for-profit universal health-care system starts at the edges, and can proceed rapidly from there during periods of restructuring. We must avoid it.**

Whatever the funding model, if the level of funding is too low, no model will be able to deliver needed services. It is essential to budget enough money to meet all the needs of a healthy society, and it is crucial to develop the fiscal capacity to sustain those expenditures without running chronic deficits. Ontario RNs know that surges in cost-cutting in health care have not led to greater efficiency. On the contrary, the big health cuts during the mid-1990s and the 2008-09 recession disproportionately hit RN employment, reducing access to RN services and raising workloads and stress among RNs who managed to retain their positions.

Cuts to health care in the 1990s led to an exodus of RNs from Ontario. Once RNs make the difficult decision to leave, it is even more difficult to bring them back, as they settle down into careers in other jurisdictions. All that Ontario investment in RN education benefited other provinces and American states. Ontarians can't afford another repeat of that experience, especially given the direct link between RN practice and positive outcomes for individuals, health organizations and budgets.[98] [121]

Ontario's health-system transformation must be driven by health considerations. Funding must be stable and predictable. Multi-year funding commitments result in better planning. RNAO believes that health spending must be realigned towards primary care and upstream interventions, but that realignment must not hide the fact that many services, such as pharmacare and dental care, are gaps in the publicly funded health system**. It must also not conceal the fact that Ontario has a large shortfall in RN positions -- the lowest RN-to-population in Canada.**[122] Those gaps and that shortfall will not be rectified if we continue to squeeze the health sector. This shortfall of RNs propelled RNAO to launch the VIANurse program on March 13, 2020, to support health care employers in rapidly accelerating their human resources capacity to meet the demands of critical staffing shortages during the COVID-19 crisis. As a result, employers' human resource crises was alleviated by RNAO's capacity to deploy, within hours, registered nurses (RN), nurse practitioners (NP), nursing students, and personal support workers (PSW) to all sectors, including nursing homes in the midst of active COVID-19 outbreaks.[123]

As a result of COVID-19, we have first-hand knowledge of the impacts on population health when there is a mix of publicly- and privately-funded health care, leaving the vulnerable, in terms of determinants of health, at risk; thereby increasing health risks and impacting health outcomes for the entire population.

> "Health officials say the virus spreads quickly in environments often where vulnerable people are gathered, such as seniors' residences, prisons and far-flung parts of the country where healthcare is already patchy."
>
> – David Ljunggren, National Post, April 30, 2020[124]

3. Align organizational types and funding models

There is considerable uncertainty about the result when different cultures, such as public and private entities or for-profit and not-for-profit entities, come together to form OHTs. How do such different organizational cultures work together? Would one prevail over the other? How would benchmarking work in this case? Complicating the long-term care sector, for example, is the role of municipalities. Municipalities operate about 16 per cent of Ontario long-term care homes, and contribute about $300 million (2014) in subsidies to those homes.[125] Would municipalities still be able to earmark funds for their own long-term care facilities, and if not, would those subsidies be lost to the system?

It is conceivable that the ministry would establish protected funding sub-envelopes to manage the challenges of aligning different organization and funding models and reduce the disruptive potential of system reform. Particularly contentious, and with direct impact on the prospect of implementing the ECCO model, is the issue of physician compensation. Traditionally, most physicians in Ontario rely on fee-for-service payments for the bulk of their incomes, but the trend in primary care is towards capitation or enhanced fee-for-service models. The move to prospective funding of provider organizations and a single funding envelope may encourage physicians into some form of capitated income or salaries.

Evidence suggests that physician compensation in the form of capitated income or salary is more compatible with the ECCO model. Relative to capitation, salaried physician payments deliver more appropriate care,[126] better access to care, more time with patients, better patient satisfaction and greater physician satisfaction.[127] Further, RNAO is concerned that the maintenance of fee-for-service billing in the form of a sub-envelope for physician funding will encourage OHTs to push services towards physicians and away from other health professionals. In any case, it is important that physician compensation be constructed in ways that promote the following:

- The realization of a health system rooted in primary care.

- The development of a fully integrated health system with interdisciplinary teams that fully utilize the education and training of all health-care providers.

4. Standardize services

**No matter where they live, Ontarians want to know they will receive a standard set of health services.** The ministry needs very clear expectations regarding the care and services that all OHTs are expected to deliver. Failing that, it will have to ensure that missing services are delivered through other channels.

Some OHT candidates plan to incorporate non-health services, such as housing placement services. RNAO encourages OHTs to include services related to social and environmental determinants of health. The ECCO model calls for strong links between primary care and social services in communities. That link comes in the form of care co-ordination embedded in the primary care system. RNAO recommends that the funding model incent the participation of community social-service agencies in OHTs.

**Ontario's new vision for health care is a bold attempt to realize aspects of a performance framework known as the Quadruple Aim that includes:**

1. **Improving the experience of patients and caregivers.**

2. **Improving population health.**

3. **Reducing unit health-care costs.**

4. **Improving the work lives of providers.**

This vision could be steered in a direction that fully integrates health care into a patient-centred system rooted in primary care. That would improve health outcomes, enhance patient and provider experience, and make the system more efficient. RNs must be engaged in the development of the system and of OHTs to help realize this outcome. The proposed changes are ambitious and have not been tested on this scale anywhere before, so the outcome is difficult to predict, and could have negative unintended consequences. Being aware of the potential consequences, and ensuring all key stakeholders are involved, will help steer the change away from dangerous areas. The OHT model has the potential for Ontario to meet the goals of Quadruple Aim, but only if it is informed by evidence and experience.

**(3) TRANSITION RECOMMENDATION 3: Embrace Ontario Health as single system planner**

Develop a single health-system planner and funder that oversees and supports networks of local health teams, allowing for enhanced health services and processes that realize the Quadruple Aim.

Action items:

- Operationalize Ontario Health as the single health infrastructure responsible for system-wide planning, funding allocation, monitoring and evaluation, and related functions.

- Prohibit involvement of Ontario Health in direct service delivery and management.

- Require that OHTs have a strong primary care foundation.

- Hold OHTs accountable for providing person-centred and co-ordinated health services that promote health, prevent injury and disease, and manage and treat acute, chronic, and palliative care needs.

- Initiate and implement a labour-relations strategy that allows for the transition of all direct health-care services and service providers currently in Ontario Health regional offices (previous LHINs) to primary care or community based organizations, while respecting collective bargaining rights, collective agreements and worker entitlements.

ECCO's vision for the structure of Ontario's health system is well-aligned with many of the government's outlined health system changes. **The ECCO model calls for a single health infrastructure with a mandate that encompasses all health sectors and is aligned with public health.** This means the entire health system is under a single planning, funding and accountability structure that will advance co-ordination and integration of services to more effectively meet the needs of people. Ontario Health has the potential to become this single infrastructure. In this role, Ontario Health is responsible for health planning, funding and accountability at the provincial and regional level, and is positioned to support local OHTs. OHTs have the potential to become comprehensive local health networks that collectively connect all health services to all Ontarians. This goes beyond *ECCO 2.0*, and RNAO welcomes this bold and comprehensive vision and the potential it brings to ensure a more connected and integrated health system overall.[7] The ECCO model has been updated to include comprehensive local health networks – through OHTs – to be the planners at the local level, and providers of co-ordinated, integrated service delivery and management with primary care at their foundation.

**Learning from the unmet potential of Local Health Integration Networks**

RNAO seeks to seize the opportunity the Ontario Health agency presents – to take full advantage of its role as whole system administrator with complete oversight, and to learn from the experiences of the Local Health Integration Networks (LHIN), which were challenged to achieve their full potential. LHINs were created in 2006 to plan, fund and integrate local health systems and enable "local communities to make decisions about their local health systems."[128] By 2010, LHINs had fully assumed their role overseeing six sectors: hospitals, long-term care homes, community care access centres, community mental health and addiction agencies, community support service agencies, and community health centres. In 2017, LHINs provided organizations within these six sectors about $26 billion in funding, representing just over half the provincial health-care budget.[129]

Despite this investment, the vision for LHINs to achieve an integrated health system was never fully realized. As the auditor general concluded in 2017, health-system integration was never clearly defined, made actionable, measured or held accountable.[129] LHINs also increasingly took on front-line care delivery services, in addition to their role as the system planner. RNAO strongly urges Ontario Health to learn from the experiences of the LHINs that prevented achievement of the planned system integration, and that it serve solely in an administrative and oversight role, completely refraining from any direct-care provision.

It is for these same reasons – structural duplication and the need for direct-care functions to be in the community – that RNAO called for the dissolution of community care access centres (CCAC) in ECCO 1.0 in 2012. For the past eight years, RNAO has continuously urged for the transition of RN care co-ordinators from CCACs (and then LHINs) into interprofessional primary care teams. While the government did away with CCACs in 2017, the care co-ordination function and staff never relocated into primary care. Instead, they, along with other front-line care providers, moved into the LHIN structure. The dissolution of CCACs removed a redundant structural

layer in the system, but it was insufficient to fully enhance clinical services for On-
tarians. We must not repeat these same mistakes with the planned dissolution of
LHINs into Ontario Health.

Structural changes alone are not sufficient to transform our health system toward the vision
of ECCO. All structural changes must lead to an improvement in clinical services for Ontari-
ans, which is only possible when we strengthen primary care and other community services.
The fact is, there is no single high-functioning health system in the world without a robust
primary care sector.[28] **The ECCO model supports a more effective use of funding to create
a more robust community care sector by re-locating all front-line care providers from
LHINs into community care, and by reinvesting the savings from LHIN-administrative
costs into community care.** This includes locating RN care co-ordinators – of which there
are now 4,500 – to interprofessional primary care organizations. This influx in health human
resources, alongside the nearly 11,000 nurses already working in primary care, will strength-
en the sector. Further, all other front-line care positions currently in LHINs – including mental
health and addiction nurses, rapid response nurses, and NPs providing integrated palliative
care – must transition into interprofessional primary care teams or other appropriate commu-
nity-based organizations (e.g. local child and youth mental health agencies).

**The role of professional associations and unions**

> **Professional associations** – Professional and sectoral associations play a central
> role in developing and supporting the roll-out of any health-system transfor-
> mation that aligns with the ECCO model, as is the case with OHTs. This includes
> providing insight and expert advice, collaborating with government to promote
> action, advancing quality through evidence-based policy and practice, and mon-
> itoring progress and accountability. RNAO is committed to proactively participat-
> ing in these efforts, and will continue to play a leadership role.

> **Unions** – Labour leaders can play a vital leadership role in developing and imple-
> menting a labour relations strategy. This includes the Ontario Nurses' Association
> (ONA) as well as other trade unions in the health-care sector. RNAO believes it is
> critical to protect collective bargaining rights and collective agreements through-
> out system transformation to ensure preservation of salary, benefit and pension
> entitlements of all health-sector workers.

**(4)** **Transition Recommendation 4: Integrate and streamline public health**

> Align independent public health entities with the integrated health system, while
increasing the overall funding to public health.

> - Increase the overall funding to public health units (PHU) and maintain the current
>   75/25 provincial/municipal split so that PHUs can:
>   - provide stronger and more consistent leadership while delivering an emer-
>     gency preparedness response for all sectors and all communities, especially
>     vulnerable populations,

- o   design and deliver population health programs that advance health equity.

- Amalgamate PHUs into a reduced number of public health entities and ensure each has the necessary expertise and capacity.

- Align the new public health entities with the geographical boundaries of Ontario Health regional offices, OHTs, and municipal boundaries.

- Require autonomous boards of health for each of the new public health entities to reflect the local population, and include membership from citizens and municipalities.

- Retain public health leadership of a chief executive officer (CEO), medical officer of health (MOH) and chief nursing officer (CNO) for each public health entity.

- Fully involve the CNO and nurses in the public health transformation agenda.

- Engage public health as an active partner in health-system transformation through close collaboration and formal linkages between public health entities, Ontario Health regional offices, and OHTs.

- Create formal linkages between Public Health Ontario (PHO) and Ontario Health.

The ECCO model calls for public health to better align and connect with the broader health system. Public health units (PHU) are responsible for protecting and improving the health of people and their communities. In Ontario, each PHU is governed by a board of health to carry out the programs and services outlined mainly in the *Health Protection and Promotion Act, 1990* and the *Ontario Public Health Standards*. These establish the minimum requirements for public health programs and services, which include population assessment and surveillance, health promotion and policy development, disease and injury prevention, health protection and emergency management.[129]

The public health workforce ensures safe food and water, safe places to live and work, and promotes and supports healthy options to maintain and improve the health and well-being of Ontarians. This includes monitoring and controlling disease, offering programs and services, and informing policy that focuses on broader issues affecting health. PHUs provide direct services to individuals to advance the health of communities – such as working with expectant and new mothers and families – while also focusing on providing broader community-level interventions.

"Governments must invest in Community Care including Public Health now. More people live in the community not in hospitals!"

– Dr. Angela Cooper Brathwaite, President RNAO, May 2, 2020[130]

The current health-system reforms include changes to public health. The government first announced its intention to modernize public health in April 2019. This included plans to reduce the number of PHUs and to change the funding model. The government later announced plans to undertake a consultation process on public health modernization. The current consultation on public health follows a series of processes carried out over the last two decades that examined the provision of public health in Ontario closely, and elicited a broad range of important findings and recommendations. Indeed, the discussion paper supporting this consultation process derives its list of key challenges from the findings of several reports over the past 20 years.[131]

Consistent with ECCO 2.0, RNAO believes that community care will be significantly enhanced if the government commits to implementing a number of these findings. Specifically, we urge the government to address these six items:

1.  Adapt and implement the recommendations of the Expert Panel on Public Health to the health system structure set out in *The People's Health Care Act, 2019* by creating deep linkages between PHUs and the regional structure of Ontario Health.

The Expert Panel on Public Health had as its mandate the development of "a strong public health sector within an integrated health system."[132] The panel identified five impacts consequent to strengthening the relationship between public health and the then-extant Local Health Integration Networks:

- Strong relationships outside the health system to protect and promote health.

- More focus on the social determinants of health and greater health equity.

- More comprehensive, targeted health interventions.

- Better care pathways and health outcomes.

- Greater recognition of the value of public health.[132]

Similarly, ECCO 2.0 and 3.0 put forward a model of community care that establishes closer ties between primary care and public health based on the distinct and complementary functions performed by the sectors in a properly integrated system. Within RNAO's ECCO model, the amalgamated public health entities maintain the role of advancing population health interventions across the health system. Their expertise will serve to advance a) social and environmental determinants of health, b) community engagement and consultation, and c) support to at-risk populations and the identification of trends-based systemic programmatic needs. These public health entities must play an increasingly important role in whole-system planning, design and delivery, as well as health-system transformation.[133] It has become progressively apparent during the COVID-19 pandemic that further integrating primary care and public health will be an essential component of successful pandemic planning, mobilization and emergency response moving forward.

The same impacts the expert panel anticipated through strengthened linkages between regional PHUs and LHINs can also be realized through deeper connections between the amalgamated public health entities and Ontario Health regional structures, which will:

- Extend Ontario Health's view beyond illness care to:

    o population health interventions,

    o social and environmental determinants of health, and

    o whole system planning, design and delivery considerations.

- Facilitate connections between the health system and social services.

- Enable a greater degree of system co-ordination to support whole system planning at the regional level.

- Align system-wide responses to evidence-based population health planning priorities.[133]

The expert panel also called for the creation of Local Public Health Service Delivery Areas in order to more deeply integrate and localize engagement between LHINs and PHUs.[134] As the health system continues to transform, RNAO further recommends the government seek and capitalize on opportunities for OHTs to engage directly with PHUs. This is supported by the Ontario Association of Public Health Nursing Leaders, and endorsed by RNAO's Community Health Nurses' Initiative Group, which notes: **"At a local and regional level, partnerships with primary care, through OHTs, present an opportunity to build on the successes of each sector to enhance population health."** By actively endorsing and supporting primary care and public health collaboration, the Ontario government is creating an environment that could lead to sustained improvement in the health of its citizens."[135] Engagement between PHUs and OHTs facilitates the opportunity for public health NPs and RNs to work closely with primary care RN care co-ordinators to support the delivery of health services and, together, create pathways to better health outcomes both within the health system and through navigation to needed social services.

As set out in *ECCO 2.0*, the evolution towards the above linkages will depend on a number of factors, including (but not limited to):

- enhancement of public health funding (see discussion below),

- retention and enhancement of public health programming,

- adaptation of governance and leadership models to current health-system transformation (see discussion below),

- protection and strengthening of the CNO, NP and RN roles in order to fully realize the contributions that public health nurses, working at full scope,

- recognition of public health's contribution to population health and wellness through a) identifying priorities through surveillance and local data, and b) engagement with community, in a system presently focused on "illness,"

- development of measures of system performance that are consistent with population health outcomes and the capacity/role of public health units,

- engagement of public health as an active partner in health-system transformation.[136]

Further, a strengthened primary care sector to serve as the key link between health care and public health is a critical factor toward the evolution of an integrated system. The work of public health programs as an integrated component of the health system will advance principles of primary health care and contribute to a long-term vision of primary health care for all.[6]

2. Reduce the number of PHUs and ensure each has the expertise and capacity to fully implement the *Ontario Public Health Standards*

Reference to the *Ontario Public Health Standards* in the *Health Promotion and Protection Act* (s.7) provides the *Standards* with legal authority, making their full implementation province-wide both a legal requirement and a reasonable expectation of all Ontarians.[137] With reference to the 2017 auditor general's report, it is noted that some PHUs do not have sufficient expertise and/or resources to fully implement the *Ontario Public Health Standards*. It is further acknowledged that uneven implementation of standards across the province has resulted in health inequities, and that the absence of full implementation exposes populations to various risks.[138]

The expert panel's recommendation to strengthen the relationship between PHUs and LHINs entailed a reduction of PHUs (from 36) to match the number of LHINs (14).[139] RNAO supported that recommendation and included the same recommendation in ECCO 1.0 and 2.0. Consistent with that recommendation, RNAO believes public health in Ontario would be strengthened if the number of PHUs were a small multiple – that is two or three – of the number of regional units of Ontario Health.

3. Adapt and implement the Expert Panel on Public Health recommendations with respect to leadership structure and governance

i. Leadership structure

Public health has a broad mandate. Consequently, a broad range of knowledge, skills and expertise is required to lead and fully implement a robust public health system.

In a timely opinion piece in light of concerns about COVID-19, Dr. David Butler-Jones, Canada's first chief public health officer and deputy minister of the Public Health Agency of Canada, reminds us:

"To understand and apply public health effectively requires expertise in everything from epidemiology and statistics, to prevention and control of disease and injury, to health policy. You also need proficiency from the management of organizations, to the complex interactions of animal and human health, the environment and economy, as well as knowledge of the biological, physical and social sciences."[140]

The reduction of PHUs, as recommended above will necessitate effective leadership, given the complexity of Ontario's public health system. The leadership structure of these organizations will call for a mix of corporate management and content-specific leaders in order to facilitate communication across the system with counterparts with same expertise.

### ii.    Nursing leadership

RNs, including NPs, represent the largest share of health human resources in public health. They bring to the public health system a broad set of skills, as well as specialized competencies and expertise. The success of our public health system, and in particular the success of efforts to connect public health to health care and more broadly to social services, will depend on the effective use of nurses' competencies, skills and expertise. Public health RNs and NPs are positioned to interact with at-risk patients and populations, identify trends in group and population health, formulate recommendations to aid in system planning and integration, and take action on addressing the social and environmental determinants of health.

**To take advantage of the competencies, skills and expertise of public health nurses for the purpose of system planning and integration demands recognition and nurturing of leadership opportunities.** The public health nursing workforce needs support and championing within the leadership structure of the PHUs, specifically in the form of the CNO. Increasingly, PHUs will need to leverage the role of public health CNOs to deliver quality and best practices in clinical and management governance, support collaborative teamwork among all public health disciplines, and foster health-system collaboration across the health, social services and municipal sectors."[141]

As set out by the Ontario Association of Public Health Nursing Leaders (OPHNL), and endorsed by RNAO, leveraging the role of public health CNOs would allow CNOs to deliver or support the delivery of the following:

- Communities of practice for public health with practice mentors at the regional level.

- Local practice environments where all nurses are supported to work at full scope in an integrated team environment, thereby increasing the efficiency and effectiveness of interventions.

- Practice excellence support for all levels of nursing (NPs, RNs, RPNs) by providing clinical mentoring and laddering opportunities across the continuum of nursing roles.

- Nursing leadership skills in team building, relationship building and negotiation to support system-wide collaboration.[142]

### iii.    Governance

The *Health Protection and Promotion Act, 1990* does not, at present, set out a specific governance model. The objective of strengthening linkages between PHUs and the health-care system through the Ontario Health structure suggests a uniformity of the governance model that imposes across boards of health a standard set of skills and experience. Further, with the reduction in the number of PHUs, and the consequent increase in population and geographic diversity of health units, representation issues increase in importance. RNAO

echoes the criteria set out by the expert panel for governance as well as the recommended features.[143] **In addition to competencies, skills and experience, RNAO identifies the need for diversity and inclusion on boards of health so that populations experiencing health inequities are given voice in the public health system.**

4. Increase funding under the existing cost-sharing arrangements to ensure stability and program continuation until a fully-informed funding evaluation is undertaken by the province with municipalities.

    i) Target potential savings from the reduction in the number of PHUs, as recommended above, to PHUs and population health programs that advance health equity.

Underfunding public health is fiscally irresponsible and undermines community care. The auditor general's 2017 report noted the number of people living with chronic disease had been on the rise in Ontario.[129] The Report also notes that in Ontario, between 2004 and 2013, diabetes incidence increased by 65 per cent, cancer by 44 per cent, high blood pressure by 42 per cent, and chronic obstructive pulmonary disease by 17 per cent.[144] **According to ICES four modifiable risk factors that contribute to chronic disease – physical inactivity, smoking, unhealthy eating and alcohol consumption – cost the health-care system $90 billion over that decade, accounting for almost a quarter of the province's health-care spending (22 percent).**[144] The health-care costs attributable to these four modifiable risk factors far outstrip the province's total investment in public health, which stood at 8.6 per cent of the total health budget in 2019.

Reducing the number of PHUs and centralizing certain shared functions to PHO ought to be seen as an opportunity for deeper investment in public health as opposed to savings. Evidence indicates there is significant return-on-investment in public health. A 2017 systematic review indicated that each dollar invested in public health results in a return of about seven dollars in avoided health- and social-care costs.[145] Similarly, the auditor general's report cites a 2009 study on disease prevention that shows a return of $6.20 for every dollar of public health spending.[146]

5. Withdraw plans to shift the financial burden of public health to municipalities until such time as the recommendations above are implemented and the system has time to operate at full functionality, including (but not limited to) the province-wide implementation of the *Ontario Public Health Standards.*

In spite of municipalities bearing legislative responsibility for funding public health, the mandate for public health is largely provincial. PHO, for example, was enacted through provincial legislation. The number and functions of PHUs are, similarly, a matter of provincial jurisdiction, as are the *Ontario Public Health Standards* to which they are accountable. RNAO believes public health ought to remain a mandate of the provincial government for the following reasons:

• Most, if not all modifiable risk factors to prevent disease are province-wide, not local.

• While health inequities place certain populations at greater risk of chronic disease, the dispersion of these populations is unrelated to municipal boundaries.

**Learning from a history of an underfunded public health system**

Ontarians know the value of a fully-funded and functional public health system. In 2000, following the downloading of public health funding to municipalities, there was an E. Coli outbreak due to drinking water contamination in the town of Walkerton.[146] Seven people died and 2,300 became ill as a consequence. In 2003, Severe Acute Respiratory Syndrome (SARS) killed 44 Ontarians, including two nurses and a physician.[147]

> "… [COVID-19] test submissions have fallen probably because testing criteria seem so restrictive. Current guidance around testing appears to still emphasize travel and case contact. That needs to end immediately…Note that the SARS outbreak was controlled entirely based on clinical case definitions as the pathogen was only recognized towards the end of the outbreak.'"
>
> – Dr. David Fisman, University of Toronto, April 5, 2020[148]

At time of writing, Ontario is caught up in the global COVID-19 pandemic. Having learned lessons from previous public health emergencies, our public health system has responded – albeit slow -- with necessary measures to protect Ontarians. Key shortfalls have been the provision of resources to respond to the pandemic, such as personal protective equipment and testing.[133] Equally important to note have been the performance variations of individual PHUs to execute the directives in a consistent way.

> "Over the last 3 months in Toronto there have been 1033 calls to EMS for opioid overdoses. 56 people have died of opioid overdose. 25 in the month of April, highest number in a month since September 2017. These aren't numbers, they're people."
>
> – Zoë Dodd, May 5, 2020[149]

Despite measures in Ontario to slow the transmission of illness, better prepare our health system, and gain further understanding of COVID-19 to guide public health recommendations in the absence of a vaccine, more could have been done. Pandemic response is dependent on a proactive investment in the infrastructure and capacity of our public health system – including its leadership – and should not only be enhanced on a reactive basis when a new public health threat emerges.

COVID-19 tests in Ontario @jkwan_md
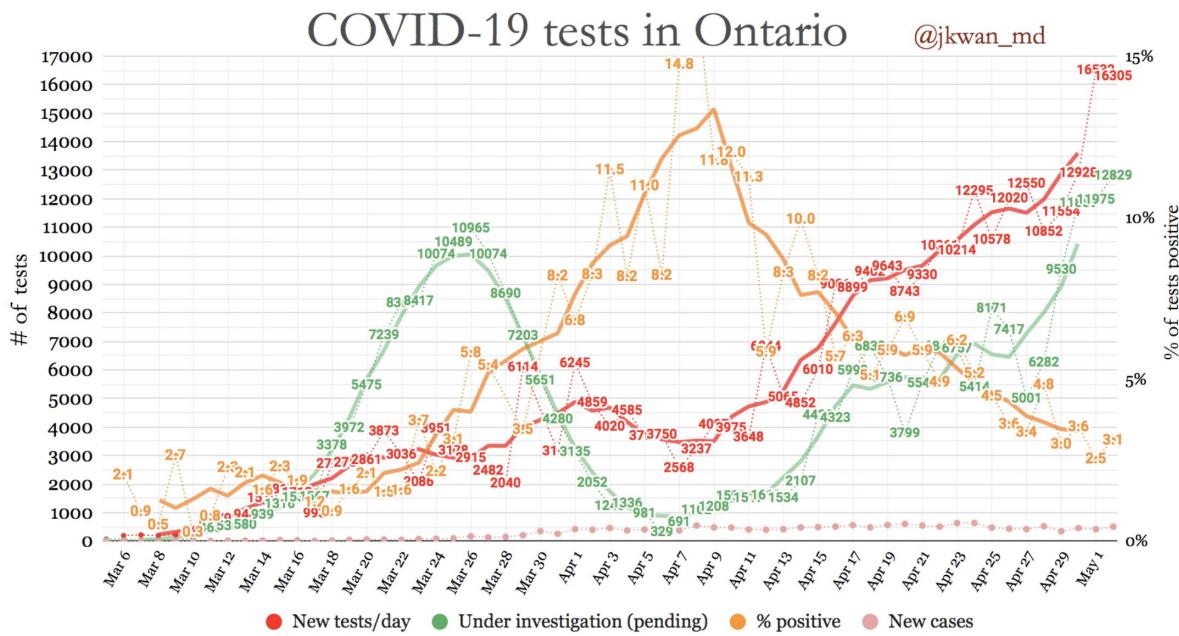
*Dr. Jennifer Kwan, May 2, 2020*[150]

The public health modernization consultation currently underway presents us with an opportunity to take stock of that history, and discuss the key challenges that remain outstanding. The many examinations of Ontario's public health system have identified what is working and what is missing, what is right and what is wrong with our system and, most importantly, have offered up practical, reasonable and evidence-based solutions for implementation. None of those involve cutting funding to public health. And none of those involve shifting the burden of funding to municipalities. **The solutions all speak to the need for time, resources, expertise and an unwavering commitment of the provincial government to the health and well-being of Ontarians through a robust integrated public health system, which includes:**

- Strategies to deal with modifiable risk factors and social and environmental determinants of health are best supported by, and sometimes led by, other provincial ministries. For example, strategies intended to deal with modifiable risk factors affecting chronic health ought to be implemented in the school system and, therefore, require the support of the ministry of education. Similarly, the public health function of facilitating pathways of care through social services – e.g. housing – depend on cross-ministry co-operation. As discussed in the 2017 auditor general's report, the levers affecting population health outcomes are so broadly distributed across different ministries of government that a number of national and sub-national jurisdictions have adopted the Health in All Policies (HiAP) approach.[151]

- While there is an existing cost-sharing formula in place between the province and municipalities, the province retains the authority to determine the distribution of funding to PHUs. Further, as demonstrated by the considerations of the Funding Review Working Group, the factors that determine the distribution of funding to public health units are largely modifiable by orders of government higher than municipal.[152]

- The functional success of PHUs will depend on the mandate and role of PHO. As identified in both the discussion document and the auditor general's report, municipalities do not have the capacity – nor would it be efficient – to implement systems to co-ordinate activities, identify and share best practices, update evidence, measure performance (consistently), and disseminate information across all PHUs.

- Financial risks and rewards of public health accrue, primarily, to the province. Most of the risks of fault or failure in the public health system are borne by the province in the form of downstream health-care costs. Similarly, most of the rewards of a functional public health system accrue to the province in the form of returns-on-investment. (See discussion above about return-on-investment of public health spending).

According to the recently released *In It Together: Clarifying Provincial-Municipal Responsibilities in Ontario*: "A government's input into how a service functions should be matched with a corresponding responsibility to pay for that service. Unfunded mandates, whereby provincial regulations require local government to perform certain actions without providing money to meet those requirements, should be avoided."[153] This is the pay-for-say principle and it ought to be followed until such time as the recommendation below reaches a different conclusion.

6. On the basis of the principle of pay-for-say, collaborate with municipalities on the terms, including timing, of an evaluation of public health system investment, including appropriate share of cost burden.

As put so eloquently by Dr. David Butler-Jones: **"Public health is a first order of public good for which governments are responsible, requiring co-operation and co-ordination across multiple levels, as public-health threats respect no jurisdiction, borders, socio-economic structures, religion or political perspective."[140]** While the mandate for public health is and ought to be largely provincial, municipalities have an interest in the system and its outcomes. The pay-for-say principle suggests an ongoing need for collaboration between orders of government and, consequently, a continuation of a cost-sharing arrangement.

In any discussion of cost-sharing, revenue capacity must be considered, as must the broad picture of municipal service compliance burdens. The 1998 Local Services Realignment process in Ontario downloaded full or partial funding responsibility for a wide variety of services, including housing, disability supports, municipal transit, land ambulance and public health, while also limiting municipal tax room. Between 1999 and 2007, the province reassumed, in whole or in part, costs of a number of services, including public health. Again, in more recent years, the 2008 Provincial-Municipal Fiscal and Service Delivery Review resulted in another round of uploading that further reduced the compliance burden on municipalities.[154] However, municipalities in Ontario still remain responsible for funding a broader suite of services, and are subject to more provincial service mandates than municipal governments in other provinces.

In its 2020 pre-budget submission, the Association of Municipalities of Ontario claimed a $3 billion gap between municipal spending on provincially mandated services and the offset provided in provincial grants. **Shifting an even greater burden of public health costs to municipalities in this context entails clear risks to the health of Ontario's population and, consequently, the sustainability of our health-care system.**[155]

RNAO believes there is room for conversation about the appropriate split in funding for public health between municipal and provincial orders of government. That discussion needs to be based on the following principles:

- Public health is largely a provincial mandate (for all the reasons set out above).

- Municipalities have an interest in the health of residents, and desire a say in how the public health system functions.

- Pay-for-say.

- Municipal revenue capacity and provincial service mandates need to be taken into account.

Further, that discussion needs to take place in the context of a fully functional and robust public health system so that linkages, synergies and the full costs and benefits of such a system are apparent to all parties. As evidenced by the incomplete and partial implementation of recommendations emerging from both the Expert Panel on Public Health and the auditor general's 2017 report, it will take some time before Ontario's public health system matures to a point that makes such a conversation constructive. As a consequence, RNAO urges the government -- in the strongest possible terms -- to freeze its plans to increase the municipal funding burden of Ontario's public health system.



*Banksy, May 2020*     **64**

# CONCLUSION

The core underpinnings of the ECCO model have not changed since the report's inception in 2012. The strategic decision to release ECCO 3.0 amid major, ongoing health-system transformation was made to ensure these changes are shaped to create a more accessible, equitable, person-centred and integrated health system.

**The shockwaves of the COVID-19 pandemic, which have impacted every person's life, ready us for bold health-system transformation.** We must decisively and definitively embrace our publicly-funded and primarily not-for-profit health system to meet trending population health needs and serve all Ontarians. We must fully lift our talent and focus on all aspects of care delivery, inspiring the collective contributions of all sectors.

We call on government to adopt the ECCO model to augment its transformation agenda. It is a robust set of solutions that – if implemented – will serve to address the many system challenges and gaps uncovered as we struggled, with the best of intentions, to work together against the pandemic in our midst.

Enhancing community care and anchoring our health system in primary care is key to strengthening co-ordination and integration across all health sectors, and should be done with central oversight from the new Ontario Health agency. The 13 recommendations that make up ECCO 3.0 will lead us through a transition process and propel us forward to a strong, robust, and integrated health system that is equipped to ensure better health outcomes for all in the future.

RNAO is eager to partner with the government to bring ECCO 3.0 to fruition, and to achieve the Quadruple Aim in our health-care system.



*Queen's Park Day, February 20, 2020, from left to right: Morgan Hoffarth, RNAO President-Elect, Christine Elliott, Ontario Minister of Health, Dr. Angela Cooper Brathwaite, RNAO President and Dr. Doris Grinspun, RNAO CEO*

# APPENDIX A: Drivers of change

## Social determinants of health

The World Health Organization (WHO) states that "poverty is the single largest determinant of health."[156] Health Quality Ontario (HQO) agrees, and further states: "The poorer you are in Ontario, the more likely you are to have worse health outcomes."[157] In 2017, 12.9 per cent of Ontarians struggled to meet their basic needs according to the low-income measure after tax.[158] The distribution of poverty is not random. Those who experience higher rates of poverty include Indigenous people, women, racialized people, new immigrants and people living with disabilities.[159] The evidence is conclusive: poverty makes people sick, acts as a cumulative disadvantage over the course of a person's life, and can even lead to premature death.[160] [161] [162]

## Social determinants of health

> The social determinants of health (SDOH) are defined by WHO as the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The SDOH are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries.[163]

Just as poverty directly impacts people's health, so too does income inequality. Reducing income inequality benefits the health of individuals with the lowest incomes, and that of the whole population.[164] More equal societies have healthier people and stronger, more resilient communities.[165] Conversely, less equal societies have worse health and social outcomes, such as lower life expectancy and higher rates of infant mortality, mental illness and substance use disorder, obesity, teenage births, homicides and imprisonment.[166]

In Ontario, much like the rest of Canada, the majority of earnings go to the richest families at the expense of everyone else.[167] The top half of Ontario families take home 81 per cent of earnings compared to 19 per cent by the bottom half.[167]The 2016 Census further illustrated the inequity in income distribution across population groups: Indigenous Canadian incomes are 25 per cent lower than for non-Indigenous Canadians; visible minorities' incomes are 26 per cent lower than those of non-visible minorities; and recent immigrants' incomes are 37 per cent lower than those born in Canada.[168]

Paid work should be a pathway out of poverty that covers basic needs (e.g. housing and food) and provides people with the opportunity to participate in their community.[169] For this to be true, jobs in Ontario need to be safe, secure and offer living wages. This is not the case for everyone in Ontario. The 2018 *Getting Left Behind* report found that while

overall job security in the Greater Toronto and Hamilton areas improved from 2011-2017, there are deep inequalities related to the background and circumstances of workers. The interaction of sex, race and education shapes who has access to secure employment.[170] The lack of decent work and living wages is taking a significant toll on the health of workers and their families.[171] People who are precariously employed have an increased risk of being sick (e.g. diabetes, heart disease and depression) and are more likely to experience fatal occupational injuries.[172 172]

In addition to decent work and living wages, Ontario needs a social security system that ensures everyone – including the most vulnerable among us – is able to meet their basic needs. This is necessary to avoid the high cost of poverty, both from the impact it has on individual health and from the cost on our health, social and justice systems. Yet social assistance rates in Ontario are inadequate. A single person on Ontario Works is eligible for a maximum of $733 per month. A person on Ontario Disability Support Program can receive up to $1,169 per month.[173] This does not reflect the actual cost of shelter and basic needs in Ontario.[174 175]

Precarious work, low wages and inadequate social assistance mean that many Ontarians cannot afford the high costs of housing, and that many go hungry. In 2017, 15 per cent of Ontario homes were unsuitable, inadequate or unaffordable – what Statistics Canada calls core housing need.[176] Ontario has the highest proportion of households in core housing need in Canada. Peterborough has the top rate among all Ontario communities at 21.9 per cent, followed by London (17.1 per cent) and Toronto (16.4 per cent).[177] The lack of affordable housing takes its toll on individuals, families and communities. Health can be further compromised because of food insecurity. According to the Canadian Community Health Survey, there were 594,900 food insecure households in Ontario in 2014.[178] The probability of food insecurity rises as household income declines: 27.5 per cent of the poorest people in Ontario report having food insecurity, compared with less than three per cent for those with annual after tax income of $40,300 or above.[179] Unless we act to decrease poverty and income inequality in our province, Ontario is in danger of going in the direction of increasing inequity and worsening health outcomes that will in turn increase demand on our health system.

**Environmental determinants of health**

We know that the environment is an important determinant of health. A conservative estimate put the 2015 Canadian illness cost of pollution at about $4,300 for a family of four.[180] There is also the threat posed by climate change. Concentrations of the greenhouse gas carbon dioxide are higher than they have been for over three million years, when sea levels were 15-25 meters higher than today.[181]

**Environmental determinants of health**

> Environmental determinants of health are involuntary exposures to external agents that cause changes in health status.182 In the developed world, that would include outdoor air quality, indoor air quality, exposure to toxics and endocrine disruptors through the air, water, food and other products or contacts, and exposure to radiation.

Globally, we are in the midst of climate change. In Ontario, temperatures are rising faster than the global average. The province is 1.5 degrees celcius hotter than it was in 1948.[183] Climate change is already affecting the health of Ontarians in many ways, including:[184] [185] [186]

- Temperature extremes are causing more illness and death from heart attacks, heat stroke and hypothermia.

- Flooding and wildfires are resulting in illness and fatalities.

- Vector-borne diseases like West Nile and Lyme Disease are spreading into Ontario due to milder winters.

- Air quality is deteriorating because heat promotes smog formation, and because of that, more wildfires. That, in turn, increases respiratory and heart diseases, allergies and asthma. Heat also promotes higher pollen counts, which is bad for asthma.

As pollution and climate change intensify in Ontario, the health effects will grow rapidly, and the province must take steps to adapt to these impacts and help people protect themselves from the increasing risks. Ontario must also budget for dealing with increased environmental illnesses through its health system. Most importantly, government must support nurses and other health professionals to play their full role in environmental health.

# APPENDIX B: Health-system reforms

The heart of health-system reform in Ontario has been the introduction of an integrated care delivery system centred around a central agency, Ontario Health, its five regional offices, and local, territorially-defined Ontario Health Teams (OHT). *The People's Health Care Act, 2019* and *The Connecting Care Act, 2019* represent a vision of a connected health-care system focused around patients, families and caregivers. This system is envisioned to be more seamless to navigate and provides strengthened local services.[187]

There have been numerous transformation initiatives that the government has recently implemented (or are ongoing) that correspond with the broader health-system reform efforts:

## Hallway health care

The Ontario government convened the Premier's Council on Improving Healthcare and Ending Hallway Medicine in October 2018. The council was tasked with identifying priorities and actions to decrease wait times, improve health outcomes for Ontarians, increase patient satisfaction and make the system more efficient.[188] The council's first report, *Hallway health care: A system under strain*, was released in January 2019. It confirmed what we have long known: key challenges contributing to hallway health care in Ontario include difficulties navigating the health-care system and a lack of care co-ordination.[188] This report was soon followed by legislation to reform Ontario's health system. The changes outlined in *The People's Health Care Act, 2019* and *Protecting What Matters Most Act (Budget Measures), 2019* lay the foundation for a transformed health-care system organized through Ontario Health and OHTs.[189][190]

These changes were followed by the council's second report, *A Healthy Ontario: Building a sustainable health care system* which outlines recommendations to improve integration, innovation, efficiency and alignment, and capacity of the health system.[191] The second report highlighted what the council heard directly from Ontarians: people want primary care to champion their needs and guide them through the complex health system. People appreciate the care delivered through integrated primary care teams, where such models currently exist. The report went on to recommend that primary care be the foundation of an integrated health-care system.[193] RNAO agrees with this finding. Ontario needs to strengthen and enhance primary care as the foundation of the health system as part of current reforms that are underway.

## Long-term care

There have been many significant policy developments that impact long-term care (LTC) homes. In July 2018, Ontario announced it would add 15,000 LTC beds over five years.[192][193] This was part of its 2018 election promise to create 15,000 LTC beds within five years and 30,000 beds within 10 years, which in turn was presented as part of its strategy to cut hospital wait times and end hallway medicine.[194]

In June 2019, the Ministry of Health and Long-Term Care was split into the Ministry of Health and the Ministry of Long-Term Care (MLTC), with Dr. Merrilee Fullerton named the new Minister of Long-Term Care.[195]

In July 2019, the *Public Inquiry into the Safety and Security of Residents in Long-Term Care* was released with 91 recommendations. Recommendation 85 called for the government to study the adequacy of staffing levels for registered staff in LTC, and report back in July 2020.[196] In response, the government appointed a Long-Term Care Staffing Study Advisory Group in February 2020 to inform a comprehensive staffing strategy. The plan was to have this implemented by the end of 2020. The determination of adequate staffing in LTC is one element of the staffing study.[197]

In October 2019, the government announced it was accepting applications to build 7,111 new beds, as the second installment of applications to build 15,000 new beds; 7,889 new beds have already been allocated. The government also announced it was accepting applications to redevelop 15,000 existing LTC beds. Both commitments are over five years. As of March 3, 2020, the same 7,889 of 15,000 promised new LTC beds had been allocated.[198] Ontario's Financial Accountability Office has reviewed the plan to create those beds, and notes that the first 7,889 beds should be in service by 2021-22.[199]

**Mental health and addictions**

The creation of the Mental Health and Addictions Centre of Excellence within Ontario Health, via The *Mental Health and Addictions Centre of Excellence Act, 2019*, and the companion mental health and addiction plan, *Roadmap to Wellness* are the highlights of recent health-transformation initiatives in this area.[200]

It has been 10 years since the Select Committee on Mental Health and Addictions released its report *Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Plan for Ontarians* in 2010. Its key recommendations included the creation of an umbrella organization that would be responsible for the mental health and addictions system, and the consolidation of all mental health and addictions programs and services.[200]

In March 2020, the Ontario government launched *Roadmap to wellness: A plan to build Ontario's mental health and addictions system* with the new Mental Health and Addictions Centre of Excellence within Ontario Health, serving as the foundation for this comprehensive strategy. Aimed at emulating the success of Cancer Care Ontario with respect to cancer care in the province, the Mental Health and Addictions Centre of Excellence will be the central body overseeing the delivery and quality of mental health and addictions services and supports in Ontario.[200]

The plan is built on four pillars:

1. Improving quality

2. Expanding existing services

3. Implementing innovative solutions

4. Improving access[200]

Ontario has committed to investing $3.8 billion over 10 years to create new mental health and addictions (MHA) services and expand existing programs.[200] The intent of the new MHA plan is to benefit all Ontarians and reach vulnerable populations, including (but not limited to): Indigenous people, children and youth, people experiencing homelessness, and people involved with the justice system.[200]

**Home and community care**

In February 2020, the government introduced *Bill 175, Connecting People to Home and Community Care Act, 2020* and accompanying proposed regulations to support a new home and community care and services regime. On March 10, 2020, the bill passed second reading and was sent to the Standing Committee on Social Policy. The government indicates the bill will make it easier for people to access home and community care in all settings. It also fits with Ontario's broader health-system transformation efforts to advance the Quadruple Aim.[201]

*Bill 175* would repeal the outdated *Home Care and Community Services Act* (HCCSA), introduced in 1994. The HCCSA created rigid barriers to integrated and innovative models of care delivery for Ontarians in their homes and communities.[201] The modernization of home and community care is long overdue, and the services and models of care must be restructured to meet the dynamic needs of an aging population, shifting client expectations, rising opportunities for care at home, and technological innovations.[201] In response, the government proposed a framework in which there is:

- o adaptable care co-ordination,

- o flexibility in care planning,

- o increased flexibility for innovative models of care,

- o no service maximums,

- o an oversight model for residential congregate services.[201]

Significant amendments to the *Connecting Care Act, 2019* can be expected if *Bill 175* is passed in order to integrate home and community care with the rest of the broader health-care system.

**Public health**

There is ongoing consultation called public health modernization that has as its centerpiece a reduction in the number of public health units. For further information on this transformation initiative and RNAO's response, please see transition recommendation 4 (pg. 54).

# APPENDIX C: Organizations consulted

The Registered Nurses' Association of Ontario (RNAO) would like to thank the many health-system experts represented below who were consulted for their significant knowledge and expertise to develop the ECCO model in its various versions. Please note that this list does not necessarily indicate endorsement of the model from the organizations or individuals included.

Association of Family Health Teams of Ontario (AFHTO)

Association of Ontario Health Centres (AOHC)

Canadian Association for People-Centred Care

CCAC case co-ordinators (various)

Community Health Nurses' Initiatives Group (CHNIG)

Fasken Martineau (Pro Bono)

George Smitherman, Chair, G & G Global Solutions, and former Ontario health minister

Home health-care nurses

Local Health Integration Networks (LHINs)

Minister of health and long-term care and senior ministry officials

National Case Management Network of Canada (NCMN)

Nurse Practitioners Interest Group (NPIG)

Ontario Family Practice Nurses (OFPN)

Ontario Nurses' Association (ONA)

Ontario's Progressive Conservative Party

Ontario's New Democratic Party

Ontario Community Support Association (OCSA)

Ontario Hospital Association (OHA)

Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP)

Patients Canada

Institute of Clinical Evaluative Sciences (ICES)

Quantum Transformation Technologies

And thank you to countless RNAO members, nurses, other health professionals and the public, who were consulted through webinars, teleconferences and meetings

# APPENDIX D: Acronyms used in report

1. **AHAC**      Aboriginal Health Access Centre

2. **BPG**      Best Practice Guidelines

3. **BPSO**      Best Practice Spotlight Organization

4. **CCAC**      Community Care Access Centre

5. **CEO**      Chief Executive Officer

6. **CHC**      Community Health Centre

7. **CHRIS**      Client Health and Related Information System

8. **CNO**      Chief Nursing Officer

9. **CNO**      College of Nurses of Ontario

10. **ECCO**      Enhancing Community Care for Ontarians

11. **EHR**      Electronic Health Record

12. **EMR**      Electronic Medical Record

13. **FHT**      Family Health Team

14. **GPFHT**      Greater Peterborough Family Health Team

15. **HiAP**      Health in All Policies

16. **HPRAC**      Health Professions Regulatory Advisory Council

17. **HQO**      Health Quality Ontario

18. **ICES**      Institute for Clinical Evaluative Sciences

19. **LHIN**      Local Health Integration Network

20. **LTC**      Long-Term Care

21. **MHA**      Mental Health and Addictions

22. **MOH**      Medical Officer of Health

23. **MOHLTC**      Ministry of Health and Long-Term Care

24. **MRP**      Most Responsible Provider

25. **NP**      Nurse Practitioner

| **26. NPLC** | Nurse Practitioner-Led Clinics |
| **27. NQuIRE** | Nursing Quality Indicators for Reporting and Evaluation |
| **28. OHT** | Ontario Health Teams |
| **29. ONA** | Ontario Nurses' Association |
| **30. OPHNL** | Ontario Association of Public Health Nursing Leaders |
| **31. P3** | Public Private Partnerships |
| **32. PCP** | Primary Care Provider |
| **33. PHO** | Public Health Ontario |
| **34. PHR** | Personal Health Record |
| **35. PHU** | Public Health Unit |
| **36. PPE** | Personal Protective Equipment |
| **37. PSW** | Personal Support Worker |
| **38. RN** | Registered Nurse |
| **39. RPN** | Registered Practical Nurse |
| **40. SARS** | Severe Acute Respiratory Syndrome |
| **41. SCOPE** | Seamless Care Optimizing the Patient Experience |
| **42. SDOH** | Social Determinants of Health |
| **43. WHO** | World Health Organization |

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## WHO WE ARE

We represent the nursing profession in Ontario, speaking out for nursing and speaking out for health.

Our mission is to pursue healthy public policy and to promote the full participation of registered nurses and nurse practitioners in shaping and delivering health services now and in the future. We believe health is a resource for everyday living and health care a universal human right.

Respecting human dignity, we are a community committed to diversity, inclusivity, democracy and voluntarism. We make leadership our mandate, working with nurses, the public, health-care providers and governments to advance individual and collective health .

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