Submission to the Ministry of Health on Bill 135, Convenient Care at Home Act, 2023

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Introduction

The Registered Nurses' Association of Ontario (RNAO) represents more than 51,000 registered nurses (RN), nurse practitioners (NP) and nursing students across Ontario. For nearly a century, the association has advocated for changes that improve people's health and use the full expertise of nurses.

RNAO welcomes the opportunity to present its views on Bill 135, *Convenient Care at Home Act, 2023.*

Commentary

Bill 135 continues the process of health system transformation in Ontario triggered in 2019 by the Connecting Care Act, by restructuring the provision of home and community care in Ontario. RNAO welcomes the dissolution of the Local Health Integration Network (LHIN) and their successors, the Home and Community Care Support Service (HCCSS) organizations.

Further, we welcome the proposed assignment of care coordinators to client provider organizations and other "frontline health settings". RNAO expects the employment status and labour rights of nurses to be fully protected. We believe that home care organizations are best positioned to coordinate the care required by their clients, provided there is accountability for quality care expenditures. We further believe that the deeper integration of health sectors that flows from the elimination of LHINs/HCCSSs makes way for innovative care and funding models that will provide better care for clients.

The need to close gaps and share full information

RNAO is troubled that the bill fails to address the critical challenges within Ontario's home and community care sector: inadequate access; critical shortage of health human resources, particularly nurses; and outdated funding models. While the proposed organizational restructuring opens up opportunities for some improvement in care, these blatant gaps must be addressed in order to improve access to and quality of home and community care in Ontario.

RNAO has always been clear about its support for deeply-integrated and publicly-accountable health teams. We point to the incorporation of Ontario Health Teams (OHT) into our Best Practice Spotlight Organization® (BPSO®) model – we are awed by their commitment to adopting and implementing RNAO's best practice guidelines to achieve clinical excellence and boost population health.

RNAO, however, cannot conclusively endorse or oppose this bill as it lacks full transparency regarding the government's plans for our health system. We can't comment meaningfully on what we don't actually know, and we are deeply concerned that the government has yet to fully define or communicate publicly the end-state of this transitional legislation. The health minister, when introducing Bill 135 in the legislature, did advise that Ontario expects to designate OHTs by this time next year (Ontario Newsroom, 2023). Yet, as we hurtle toward this date, critical and determinative characteristics of these OHTs – funding, governance and public accountability measures – have yet to be revealed to Ontarians.

Vision for home and community care in Ontario

RNAO's vision for Ontario's health system, including the home and community care sector in Ontario, is detailed in three reports titled *Enhancing Community Care for Ontarians* (ECCO) (RNAO, 2012; RNAO, 2014; RNAO, 2020). The ECCO report series states that our health system must be:

- accessible, with interprofessional care teams anchored in primary care where people live, work and play
- person-centred, where a person and their support system are viewed as a whole and empowered to be genuine partners for their own health
- equitable, where deliberate efforts are made to decrease gaps in health outcomes, services and experiences
- integrated, where care is coordinated so that transitions from sector to sector and service to service are all seamless
- publicly-funded and not-for-profit, so that it is sustainable, efficient and equitable and everyone – no matter their means – receives the care they require

In ECCO 3.0, RNAO welcomed Ontario's health system transformation agenda and strongly supported the formation of OHTs (RNAO, 2020). We believe that OHTs need to adhere to the attributes set out above – they must be grounded in community care and anchored in primary care. This requires home and community care options to be maximized by:

1. **Providing home and community care directly through OHTs and health service providers:**
    - Dissolve HCCSS/LHINs and transition the provision of home and community care to OHTs and client providers and re-locate all care coordinators from HCCSSs/LHINs directly into front-line care organizations. Reinvest all cost savings back into home and community care.
2. **Facilitating sectoral integration and access to home and community care services by embedding RN-led system navigation in primary care:**
    - Situate RN care coordinators and navigators in primary care to facilitate system navigation, including the provision of referrals for home care services. Allow care coordinators in home care to oversee the home care assessments, care plans and services, while maintaining information sharing with primary care**.**
    - Fund NPs in correctional facilities to facilitate navigation between correctional facilities and home care and community services upon release (Office of the Chief Coroner, 2018).

3. **Improving access to OHTs and home and community care services, to include as follows:**
    - Expand the publicly-funded basket of home and community care services to include RN psychotherapy, and guarantee access for all Ontarians regardless of geographic location. Ensure that the qualifying criteria for services are clear and equitable.
    - Improve staffing, skill mix, and terms and conditions of work in the home-care sector to ensure that there are adequate health human resources**.**
    - Ensure compensation and benefits parity in all sectors by harmonizing upwards within each category of nurse – NP, RN, and RPN. The end goal should be retention of nursing talent and stability of the community sector as an element needed to ensure care continuity and quality outcomes.
    - Harness the expertise of RNs by widely implementing and expanding RN prescribing, which will significantly enhance access to high-quality care within community care settings.
    - Increase the scope of practice of NPs by allowing them to complete Forms 1 and 42. This will be instrumental in facilitating timely care for clients experiencing mental health issues in the community.

4. **Implementing contract and funding models for home and community care that promote and ensure accountability for quality, person-centred care:**
    - Fund models of care that provide for caregiver continuity and emphasize expert clinical and relational care as opposed to the pay-per-visit, transactional funding model.

Key issues with home care in Ontario today

In contrast to RNAO's vision for the home and community care sector, home care in Ontario today is plagued by fundamental issues that compromise the care provided to people in Ontario. These include:

1. Inadequate access to home care services

Current and future access trends

Current trends in the Ontario health-care system point to inadequate access to home care:

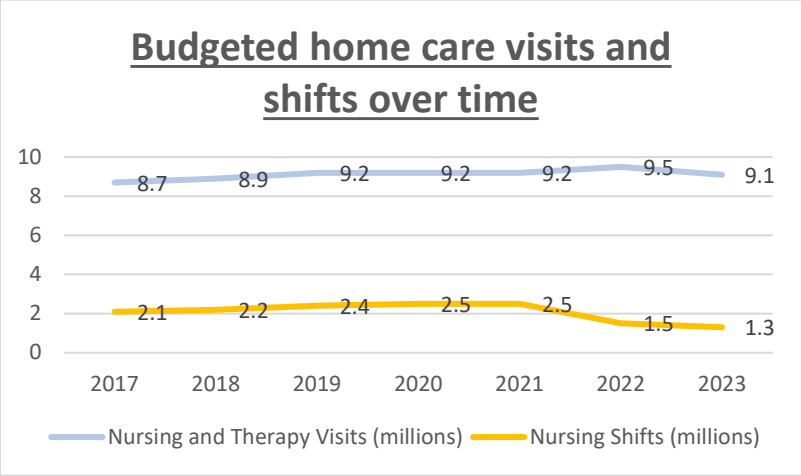
- Every year in Ontario, more than 150,000 Ontario residents privately fund more than 20 million hours of home care, demonstrating that the publicly-funded home care system is not meeting current care demands (Home Care Ontario, 2020)
- As of October 2022, there were more than 15,000 people on a waiting list for home care in the province (SE Health et al., 2022)
- As of September 2022, 540 hospital beds were occupied by "alternate level of care" patients – people waiting for home care support who did not require the intensity of services provided in hospital (FAO, 2023a)

- Eight per cent of newly admitted long-term care residents in Ontario – close to 8,000 Ontarians – could have been kept at home with the right supports in their communities (OCSA, 2022a and 2022b)

Changing demographics also point to the urgent need to enhance and expand home and community care. For example, the number of Ontario seniors (aged 65 and older) is projected to increase by 22 per cent from 2021–22 to 2027–28, which will significantly increase the demand for home care and long-term care services (FAO, 2023a).

Despite promises from the Ontario government to expand home care, the provincial budget revealed that the number of budgeted nursing and therapy visits and the number of budgeted nursing shifts for 2023 are less than in prior years (see figure 1).

Figure 1



Source: Government of Ontario Budgets (2017, 2018, 2019, 2020, 2021, 2022, 2023)

Moreover, in 2022–23, there were nearly 340,000 fewer nursing visits and over 140,000 fewer hours of nursing shift care provided to clients, compared to 2021/22. There were also less clients who received these nursing services in 2022–23, compared to the prior year. The Financial Accountability Office has projected a future decline in the number of nursing and personal support hours per Ontario aged 65 and over, from 20.6 hours in 2019–20 to 19.4 hours in 2025–26 (FAO, 2023b).

Duplication in intake, assessment and care coordination processes

Organizations that provide home and community care have repeatedly identified that Ontario's home care system contains multiple layers of administrative oversight, creating duplication in client intake processes, assessments, and care coordination (SE Health et al., 2022). And, as it currently stands, responsibility for care coordination is separate from the provision of home care services. This duplication

results in unnecessary delays in clients accessing services, as well as inefficiencies, disjointed care, and excessive costs to the system (RNAO, 2012; RNAO, 2014; RNAO, 2020; SE Health et al., 2022).

A 2015 review of home care services by the Ontario auditor general found that 40 per cent of overall home care funding went to administration, rather than front-line care (SE Health et al., 2022; Vincent, 2022). The dissolution of community care access centres removed a redundant structural layer in the system, but it was insufficient to fully enhance clinical services for Ontarians. We must not repeat these same mistakes with the planned dissolution of HCCSSs/LHINs (RNAO, 2020).

2. Outdated funding model

Multiple home-care organizations have laid bare the need for the Ontario government to update home and community care fee schedules because:

- service providers are paid based on visits, rather than client outcomes
- the current funding model – compensating service providers for each visit, with more visits yielding more compensation – provides too little opportunity for person-centred care and too few incentives for quality improvement
- employees are forced to seek alternative work during times when service volumes decline and their main employment income drops (SE Health et al., 2022)

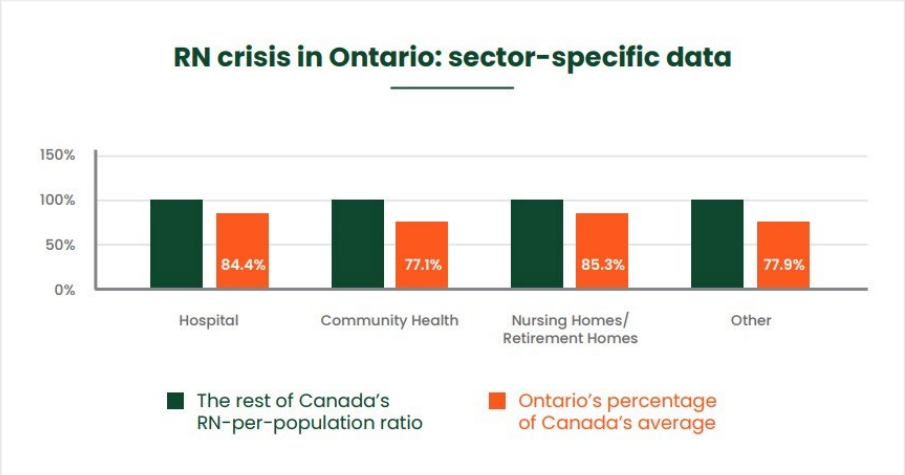
In addition, the current funding model based on the decision to share contracts for patients across different providers sometimes means that those service providers offering a full range of services 24/7 are required to share these services with other providers who may be awarded part of the contract, i.e. nursing from one provider agency and personal support from another; or nursing from one provider agency during the day and from another during the evening and night. This piecemeal approach to care will not enable the continuity of care nor of caregiver needed to support an improved patient experience, provider experience and health outcomes (RNAO, 2020).

3. Nursing resources crisis affecting home and community care

RN human resources crisis

Ontario is in the midst of an RN crisis, which must be urgently addressed. Over the course of the pandemic, Ontario's RN deficit increased from nearly 22,000 to 25,000 compared to the rest of Canada on a per capita basis. This means Ontario now needs 25,000 more RNs just to bring the province to the same RN-per-capita ratio as the rest of the country (see figure 2 on next page). Ontario's RN deficit compared to the rest of Canada exists across all sectors of the health system, especially community health care.

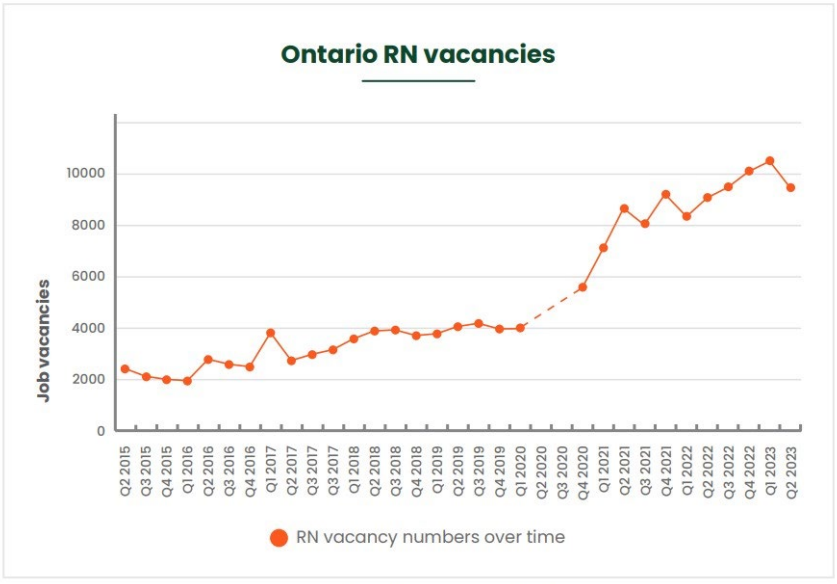
Figure 2



Source: Calculation by RNAO. RN Statistics from Canadian Institute for Health Information (2023). Population Statistics from Statistics Canada (2022).

According to Statistics Canada (2023), the number of RN vacancies in Ontario has remained around 10,000 since the last quarter of 2022 (see figure 3). The number of Ontario RN vacancies unfilled for 90 days or longer has more than doubled since the start of the pandemic. The RN understaffing crisis demands immediate action to promote the retention and recruitment of RNs in Ontario (RNAO, 2022; RNAO, 2023).

Figure 3



Source: Statistics Canada (2023)

Nursing human resources and home care

The home-care sector has historically experienced a turnover rate of up to 40 per cent, as staff members leave to pursue work in better-paying sectors (SE Health et al., 2022). The pandemic caused a further depletion of staffing levels in this sector. The Ontario Community Support Association cited a 421 per cent increase of vacant RN positions from 2020 to 2021 (OCSA, 2022c), and Home Care Ontario reported that the sector lost approximately 3,000 nurses during the pandemic (Home Care Ontario, 2021a).

Much of the RN deficit in the home- and community-care sector can be explained by system-wide inequities in compensation. It is difficult to retain staff in the home and community care sector due to much lower wages and benefits than in other health sectors. For example, an RN earning $47.75 per hour in a hospital would earn $44.14 per hour in a long-term care home and only $36.98 per hour in home care (SE Health et al., 2022).

The staffing crisis in home care, especially in the context of a pandemic, has translated into a decreased capacity to provide home-care services. The provincial acceptance rate for home care, which measures whether home care service providers are able to fulfill an urgent request for care, fell to 60 per cent in 2021 from a pre-pandemic acceptance rate of 95 per cent (Home Care Ontario, 2021b).

Analysis of Bill 135

Bill 135 does little to address these critical issues in the home- and community-care sector, and the implications of the organizational restructuring that will flow from the legislation is unclear. Broadly speaking, the structural reorganization of the sector in Bill 135 does not, in and of itself, bolster access to or the quality of home and community care services in Ontario. This is a missed opportunity.

RNAO has long supported the removal of redundant structural layers in the health system (RNAO, 2012; RNAO, 2014; RNAO, 2020). We consider LHINs/HCCSSs as such a redundant layer. While not directly addressing today's fundamental issues in the sector, we endorse the dissolution of LHINs/HCSSs and the assignment of LHIN/HCSS care coordinators to primary care and home care to enhance access and person-centred care. Integration within OHTs is bringing to life innovative models of care, such as transitioning from hospital to home, that are expediting care and enhancing care continuity while circumventing the LHIN/HCCSS-focused care procurement processes.

With reference to the assignment of care coordinators to other front-line settings, Bill 135 could also open up the possibility for RN-led system navigation in primary care (RNAO, 2012; RNAO, 2014; RNAO, 2020). Evidence points to the effectiveness of integrated health systems anchored in primary care (Aggarwal and Hutchison, 2012; Aggarwal et al., 2023; Baker & Axler, 2015; Lopes et al., 2022; OPCC, 2015; Starfield, 2009; Starfield & Shi, 2002; Starfield et al., 2005; Wodchis et al., 2015). The population health approach, which informs the creation of OHTs, requires a robust primary care system to serve as the main point of access to health care. System navigation from a base in primary care will, therefore, enhance integration of health sectors and to needed social services (RNAO, 2020).

Conclusion

The government has failed to address through this home-care bill the core challenges in primary care and home care – access, funding models and an acute nursing shortage. This is a missed opportunity that will limit the progress of health system transformation and capacity to serve Ontarians. It is imperative that these issues be addressed urgently by government, employers and associations.

Bill 135 is a transition to an end-state that remains undefined, and as such we can offer no conclusive view on most of the bill's provisions. And, with the critical terms of OHT funding, governance and public accountability still undefined, our government's progress to-date on system integration could yet come undone.

While the organizational restructuring that will flow from Bill 135 is still unclear, we have offered, above, a hopeful view of the potential of these changes to enhance access and open up the possibilities for the implementation of new person-centred care. This will require commensurate funding in primary care and home care.

RNAO's view is that our health system hangs in the balance until such time as our leaders define and share publicly the end-state of the desired transformation of Ontario's health system. Yet many questions remain unanswered. As a matter of democratic principles, including transparency, and democratic practices, including the use of the legislative process to encourage and engage in debate about our collective future, our government must define the health system it intends to create through Bill 135 and the whole succession of bills that follow from the Connecting Care Act.

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