# Submission re proposed new regulation under the Connecting Care Act, 2019

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# Introduction

The Registered Nurses' Association of Ontario (RNAO) represents more than 51,650 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 through the full expertise of nurses.

RNAO's vision for Ontario's health system, and our detailed roadmap for its achievement is highlighted in various reports, including the *Enhancing Community Care for Ontarians* (ECCO) series (RNAO, ECCO 2012; RNAO, ECCO 2014; RNAO, ECCO 2020).

Our ECCO model proposes a health system that is:

- **universally 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 full partners for their own health,
- **equitable:** where deliberate efforts are made to decrease gaps in health outcomes, services and experiences,
- **integrated:** where care is co-ordinated so that transitions from sector to sector and service to service are seamless, and
- **publicly-funded and not-for-profit:** to achieve sustainability, efficiency and equitable access for everyone – no matter their means.

RNAO welcomes the opportunity to present our views on the proposed new regulation under the Connecting Care Act, 2019[1] (the Act) related to Ontario Health Team (OHT) designation. Our analysis is informed by the ECCO model and other key RNAO policy and clinical guidelines and reports, including:

***Policy reports:***

- *Black Nurses Task Force Report*
- *Primary Solutions for Primary Care*
- *Nurse Practitioner Task Force: Vision for Tomorrow*
- *Nursing Career Pathways*

***Clinical best practice guidelines:***

- *Clinical Practice in a Digital Health Environment*
- *Person- and Family-Centred Care*

[1] Connecting Care Act, 2019, SO 2019, c 5, Sch 1, <https://canlii.ca/t/5657l> retrieved on 2024-04-08

- *Transitions in Care and Services*

***Consultations and submissions***:

- Home Care Guarantee for the People of Ontario - RNAO's Response to Bill 175: Submission to the Standing Committee on the Legislative Assembly
- RNAO response to the Ministry of Health consultation regarding home care modernization: contracting
- RNAO Submission Re Bill 135, Convenient Care at Home Act, 2023

## Preamble

RNAO is a staunch advocate of health system transformation that aims to strengthen health for all – locally, provincially, nationally and internationally. To this end, RNAO helped shape the inception of Ontario Health Teams (OHTs), and continues to support them in order to advance integrated health systems of care. Further, RNAO is partnering with several OHTs to help them implement RNAO best practice guidelines (BPG) and boost staff engagement through our Best Practice Spotlight Organization® (BPSO®) social movement of science. The OHTs working with us through our transformation-driven BPSO OHT model are already demonstrating greater integration, clearer co-ordination of services, common client-centred approaches, and attention to evidence across sectors.

Underpinning health system transformation are two key principles: 1) integrated care, and 2) population health management. These principles – aligned with RNAO's ECCO model – are foundational to all health system transformation activities. Also integral are the values of equity, diversity and inclusion (EDI), as made clear from several recommendations in RNAO's *Black Nurses Task Force Report*. Any true and meaningful health system transformation must be guided by and conform to these principles and values.

RNAO's proposed additions and amendments to the draft regulation center on the prerequisites for OHT designation. Designation marks a significant milestone on the road to OHT maturity and a new funding regime for health care in Ontario: the integrated funding envelope. RNAO's view is that the ministry and the health system are well positioned to issue a regulation that hastens the road to full maturity. Our proposed amendments to the draft regulation – outlined below – will ensure that OHTs be designated only when closer to full maturity. This will ensure – as explicitly stated in the government's health system transformation vision – that they are structured and governed in a manner reflecting the key principles from the outset.

RNAO was encouraged by the minister's 2023 disclosure that MOH was working on an "OHT maturity framework" to guide OHTs. As a next step, RNAO urges the ministry to release the OHT maturity framework as an evergreen document and contextual centerpiece for ongoing engagement with system stakeholders.

While RNAO recognizes that the process of transforming the health system is a necessarily iterative process, it is challenging to conduct a full and proper assessment of each iteration – whether legislative,

regulatory or policy – absent a clearly defined end-state. Critical and determinative characteristics of OHTs such as funding formulas and accountability measures have yet to be revealed to Ontarians. As these characteristics have important implications for nurses and the public, RNAO is eager to participate in this and other consultation processes, but would welcome fuller information going forward.

In the absence of an OHT maturity framework, RNAO offers the below recommendations to amend and/or add to the proposed regulations reflecting:

- the principles of care integration and population health management through an EDI lens
- a health system that is universally accessible, person-centred, equitable, integrated, publicly-funded and not-for-profit

## Section 2(1) of the draft regulation

### Recommendation 1: Public health representation on the board of the co-ordinating corporation

Amend section 2(1) of the proposed regulation to require the by-laws of the board of directors to include the participation of a representative of an intersecting public health unit as the board member with experience and competencies in population health management.

**Rationale:**

A stated purpose of health system transformation and function of OHTs is population health management (Ontario Ministry of Health, 2024b), which is a specific function and expertise of public health. While the ministry of health has given a role in advancing population health to primary care networks (Ontario Ministry of Health, 2024b), public health is also needed to support these population health functions, as evidenced by the engagement of public health personnel in the vast majority of OHTs (Cummins, 2023). Primary care and public health have distinct and complementary functions (Cummins, 2023). Establishing closer ties between primary care and public health reflects whole-system planning, design and delivery (RNAO, 2020a). Having population health management expertise on the board also embodies the "whole-of-government" approach.

Further, public health would facilitate the process of care integration by bringing:

- **expertise in intersectoral collaboration**. These include health care, education, social services, government and community organizations to address disparities, EDI, and foster a broad approach to health needs and outcomes.
- **resources on population health management and ability to foster and/or co-ordinate intersectoral integration.** This enables a collaborative and comparatively mature platform for care integration.
- **robust expertise in health policy, population data analysis, surveillance and programming that addresses health inequities.** These are foundational resources to effectively address population health management.

Having population health management expertise on the board without representation from the public health sector would result in entirely preventable gaps and inefficiencies, and would hamper the capacity of already high-performing OHTs.

| Vision: | Objectives: | Functions: |
|---|---|---|
| Public health will provide population health management through policy making, data surveillance and programming changes to address health disparities and EDI to improve health equity. | Within the OHT, public health will have four core objectives:<br>1. Collect and analyze race-based and other equity data to identify priority populations and support policy-making and effective programming.<br>2. Design and implement programs that address determinants of health – social and environmental – tailoring services for the identified priority populations and communities.<br>3. Evaluate the effectiveness of services and programs through an EDI lens.<br>4. Work closely with PCNs and provide support to PCNs in care delivery. | To support the above vision and objectives, the following functions are identified for public health:<br>1. Collect and analyze population data, especially race-based data within the OHT.<br>2. Provide data and evidence related to the OHT for decision-making and policy formation.<br>3. Support OHT population health management approaches and implement population health management programs and services.<br>4. Collaborate with other stakeholders such as primary care providers, community partners and government organizations, to facilitate programs that engage communities and clients in addressing determinants of health that improve health equity.<br>5. Support local population health human resource planning within individual OHTs. |

### Recommendation 2: community representation on the board of the co-ordinating corporation

Amend section 2(1) of the proposed regulation to require the by-laws of the board of directors to include community representative(s) from the OHT's attributed population.

**Rationale:**

Population health management has been an objective of health system transformation in Ontario from the outset, as triggered by the passage of the Act (Ministry of Health, 2022). Meaningful community engagement, in the form of voices on the board of the co-ordinating corporation, is pivotal to population health management. Why?

- We need to ensure equitable access to historically marginalized communities. These communities are identified, in part, in Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework (Ontario Health, 2020).

- Ontario Health and Ontario Health Teams must also address the exclusion of other equity-deserving communities, such as those under the 2SLGBTQI+ umbrella.

- We must also ensure equitable access to newcomer communities. Ontario's ethnically-diverse communities and newcomer communities have more residents unattached to primary care (Inspire-PHC, 2022; Kiran, 2022).

Community representation strengthens our capacity to address specific community needs, including:

- providing culturally-safe care in both historically marginalized and newcomer communities,

- ensuring person-centred, inclusive and appropriate health and social services for sexually and gender diverse communities (RNAO, 2020c),

- addressing specific health challenges of equity-deserving communities that often experience access barriers, higher rates of chronic illness (e.g., hypertension and diabetes), and compromised health outcomes,

- engaging community members in program planning and decision-making processes to increase program effectiveness and sustainability, and

- building trust between the community, health providers, the health system and social service providers.

OHTs also need information about upstream determinants of health within our communities – the lived experiences of community representatives are crucial to design and develop appropriate interventions, responses and resourcing within both health and social services. The social and environmental determinants of health (for example, one's race, housing, income, or access to safe drinking water), and the many ways they intersect have a substantial impact on health outcomes. For example, people

experiencing homelessness have an increased risk of premature death, morbidity, mental illness and substance abuse (Forchuk et al., 2023), and racialized groups had higher rates of COVID-19 infection and hospitalization than their non-racialized counterparts during the pandemic (Ontario Health, 2021).

| Vision: | Objectives: | Functions: |
|---|---|---|
| Community representatives will address specific needs and provide insights within OHTs to improve health-care and social delivery services. To improve health equity, they will engage in policy making, program planning and delivery, and evaluation of interventions. | Within the OHTs, community representatives will have three core objectives:<br><br>1. Identifying inequities in access to health-care and social services resulting in poor outcomes for the community,<br><br>2. Providing a voice for their community in policy making, program planning and delivery to improve health equity, and<br><br>3. Inspiring community engagement in the determination of health and social services planning and delivery. | To support the above vision and objectives, RNAO has identified the following functions for community representatives:<br><br>1. Address unique community needs and challenges and shared lived experiences.<br><br>2. Participate in program planning and decision-making to improve care delivery and ensure culturally safe care and appropriate care for sexually and gender diverse communities.<br><br>3. Advocate for programs that address the social and environmental determinants of health and support the primary care network to connect people to the services they need for health and wellbeing (RNAO, 2020a).<br><br>4. Participate in evaluating the effectiveness of services and programs through an EDI and anti-racism lens.<br><br>5. Facilitate community engagement with other stakeholders such as primary care providers, public health, patients, families, caregivers and social services to improve care delivery for patients.<br><br>6. Inform local health human resource planning. |

### Recommendation 3: Primary care network representation on the board of the co-ordinating corporation

Amend section 2(1) of the proposed regulation to require that bylaws of the co-ordinating corporation require that at least two voting members of the board of directors – one nurse practitioner and one physician – be selected by the primary care network.

**Rationale:**

Assembling a board of directors with interdisciplinary representation of primary care clinicians who have complementary and diverse knowledge and skills is vital to the clinical governance of co-ordinating corporations within OHTs (Odutayo, n.d.). This ensures that quality primary care is delivered within OHTs and maintains high clinical standards with effective system performance through co-ordinated and integrated services (Ghavamabad et al., 2021). In particular, the involvement of nurse practitioners (NP) in health system transformation must increase drastically (RNAO, 2021).

Publicly funded, team-based models of care including NPs are shown to improve NP integration as valued members of primary-care teams and have excellent results on multiple quality metrics such as improved patient satisfaction, enhanced quality of care, and lower health services costs (DiCenso & Bryant-Lukosius, 2010; Maier et al., 2017). Team-based primary care models are the gold standard in high-performing health systems, advancing timely access to quality care. Robust primary care teams are also crucial to improving care and outcomes for underserved and vulnerable populations, especially those with higher illness burdens due to poverty, health co-morbidities, mental illness and other social and environmental inequities (Nurse Practitioner Led Clinic Association & Nurse Practitioner Association of Ontario, 2019; Association of Ontario Health Centres, n.d.).

RNAO's *Vision for Tomorrow* report (2021) posited NPs as integral to OHTs – these clinical experts can function as health system navigators, providing cross-sector care for displaced clients to ensure they are not left untreated. NPs in this role will require cross-sector privileges within OHT boundaries allowing them to serve the health needs of vulnerable and underserved populations. To achieve this, NPs must be represented on co-ordinating corporation boards.

Ontario's health system and social services sector are both complex. Primary care network representation from an NP and a physician on the board will deepen the integration of clinical expertise and program design, resulting in care delivery that is responsive to community needs within OHTs (Ghavamabad et al., 2021).

Primary care is delivered in multiple settings by a wide variety of regulated professions:

- **interprofessional teams** (e.g. nurse practitioner-led clinics, community health centres, Aboriginal health access centres, family health teams and family health organizations), and

- **independent practices** such as solo providers, walk-in clinics, outreach services and youth wellness hubs

| Vision: | Objectives: | Functions: |
|---|---|---|
| 1. Facilitate the integration, coordination and distribution of primary care services within OHTs.<br><br>2. Develop NP roles in OHTs to have NPs function as clinical experts and system navigators for patients, in accordance with identified population health needs (RNAO NP Vision for Tomorrow report, Recommendation #2.1).<br><br>3. Promote the use of a systematic planning process for NP role development and implementation within OHTs (RNAO NP Vision for Tomorrow report, Recommendation #2.2).<br><br>4. Develop clear policies, communication strategies and education regarding NP role definition and responsibilities that enable NPs to successfully integrate into both new and established roles (RNAO NP Vision for Tomorrow Recommendation #2.3). | Requiring a NP and a physician on OHT boards of directors serves as a vehicle for:<br><br>1. Promoting the primary care network's voice in OHT planning and decision-making.<br><br>2. Optimizing the role of NPs within the primary care system and within OHTs at large. | 1. Engage with primary care networks to support their vision, objectives and functions through strategic planning and management within OHTs.<br><br>2. Participate in community engagement within OHTs.<br><br>3. Facilitate the integration, coordination and distribution of primary care services within OHTs through decision-making and voting.<br><br>4. Establish specific types of PC committees in partnership with PCNs to assist the board with various aspects of their work (Ontario Ministry of Health, 2024a).<br><br>5. Benefit from NPs clinical and practical expertise by establishing significant roles for them in primary care. |

## Section 2(2) of the draft regulation

### Recommendation 4: Primary care networks – functions and structure

Amend section 2(2) of the proposed regulation to:

- require the integration of social services in primary care networks, and
- include among the functions of primary care networks the development of and support for a system to co-ordinate care and navigate patients to appropriate health-care and social services.

**Rationale:**

Primary care is most often the gateway to the health-care system (Misra et al., 2020). Social services representation within primary care networks should be a precondition for OHT designation, given that appropriate social supports (e.g. housing supports, income supports and food security) are often needed to support health. Integrating social service supports with primary care addresses determinants of health and responds to the needs of the whole person.

Comprehensive care co-ordination and system navigation are essential components of a well-functioning primary care system (Kiran et al., 2020). Care co-ordination improves access to other forms of health care – including specialized services – and supports continuity of care (RNAO, 2020a; Bloch & Rozmovits, 2021). System navigation from primary care provides access to complex social service networks (RNAO, 2020a). NPs and RNs acting as primary care co-ordinators can contribute their expertise and health system knowledge by providing comprehensive care co-ordination and system navigation across the care continuum for people living in Ontario, especially those with complex clinical and/or social needs (RNAO, 2020a).

| Vision: | Objectives: | Core functions: |
|---|---|---|
| Primary care networks will connect, integrate and support primary care providers within OHTs to improve care and social service delivery and co-ordination for patients. | Integrating social services in primary care networks will:<br><br>1. improve access to social services within the attributed population to address social determinants of health and support health care.<br><br>2. improve access to primary care and reduce health inequities by supporting patients with system navigation and care co-ordination.<br><br>3. organize and represent the local primary care sector and social services sector in OHT planning and provide a voice in OHT decision-making.<br><br>4. support OHTs in the implementation of local and provincial priorities. | As outlined in section 2(2) of the draft regulation, and provided RNAO's proposed regulatory amendments are made:<br><br>1. Promote enhanced collaboration and cooperation among primary care providers within the OHT.<br><br>2. Provide input into the decision-making of the OHT's co-ordinating corporation.<br>3. Support clinical change management and population health management approaches amongst primary care providers within the network and within the OHT.<br><br>4. Facilitate primary care provider access to clinical and digital health supports.<br><br>5. Support primary care health human resource planning |

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|---|---|---|
| | | within the OHT.<br><br>6. Develop and support a system of care co-ordination and system navigation to health and social services. |

### Recommendation 5: Mental health and substance use networks

Amend section 2(2) of the proposed regulation to add a requirement for a mental health and substance use (MHSU) network in every OHT as a precondition of designation.

**Rationale:**

The delivery of mental health services in Ontario is fragmented and poorly co-ordinated with inequitable access. This creates barriers for individuals to receive the right care, in the right place, at the right time.

The range of services required to address MHSU is enormously complex and wide-ranging. These services are provided by a wide variety of regulated health professionals, including nurses. They should be considered part of a continuum of care, meant to be embedded in all health sectors – from community care to acute care (RNAO, 2020a). Current delivery channels include:

- public health (e.g. health promotion and prevention programs across a broad range of health, community and school settings),
- a mix of private, for-profit services alongside publicly-funded, not-for-profit services,
- a mix of in-patient settings (e.g. mental health hospitals, treatment facilities) and outpatient programs, and
- community-based settings (e.g. primary care, outreach, telemedicine).

Yet, current MHSU services are geographically very uneven, with only 17 consumption and treatment service sites and 22 youth wellness hubs to serve this vast province. The challenges accessing and navigating mental health and substance use services in Ontario can be linked to these poor and declining health outcomes:

- Deteriorating self-rated reports of mental health from 2019 to 2022, with Ontario fairing poorly against other jurisdictions in Canada (Government of Canada, 2022b).
- Increasing prevalence of suicidal ideation between 2019 and 2021 (Government of Canada, 2022a).

- Steady rise in drug toxicity deaths over the last decade, with a doubling of opioid toxicity related mortality over the course of the pandemic (Interactive opioid tool, n.d.).

- Little change in mental health and substance-use-related emergency department visits and hospital admissions since 2020 (ICES, n.d.).

To ensure individuals receive the mental health supports and services they need, MHSU services within OHTs must be:

- internally networked to facilitate navigation and co-ordination within/between MHSU services,

- networked with services outside the OHT, and

- universally accessible to patients, clients and residents across all sectors of the health system and social services.

In particular, MHSU services should be navigable from primary care – including co-ordination of and referral to specialty services. Primary care has a unique and central role in early identification and management of MHSU, as most individuals in Ontario access the mental health system through their primary care provider. We also know that high volumes of patients are forced to rely on their primary care provider to address their mental health needs while simultaneously managing co-morbid medical conditions (Moroz et al., 2020; OMA, 2020).

| **Vision:** | **Objectives:** | **Functions:** |
|---|---|---|
| MHSU networks will connect, integrate, and support health-care providers within and between OHTs to improve the accessibility, delivery and co-ordination of care for patients across sectors, including social services (Ontario Ministry of Health, 2024b). | 1. To network local MHSU services and provide a voice in OHT planning and decision making.<br>2. To serve as a vehicle to support OHTs in the implementation of local and provincial priorities (Ontario Ministry of Health, 2024b).<br>3. To advance population health within an OHT, with a particular focus on marginalized and equity-deserving populations such as Indigenous, 2SLGBTQI+, and Black communities in alignment with Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework. | To support the vision and objectives set out above, the following functions have been identified for MHSU networks:<br>1. Connect MHSU services within the OHT and between OHTs (Ontario Ministry of Health, 2024b).<br>2. Serve as a vehicle for representing the local MHSU sector in OHT decision-making and planning (Ontario Ministry of Health, 2024b).<br>3. Support OHT clinical change management and population health approaches (Ontario Ministry of Health, 2024b). |

| | | |
|---|---|---|
| | | 4. Facilitate access to clinical and digital supports and improvements for MHSU care (Ontario Ministry of Health, 2024b).<br><br>5. Support health human resource planning within the OHT (Ontario Ministry of Health, 2024b). |

## Section 2(3) of the draft regulation

### Recommendation 6: Minimum services/sector participation

Amend section 2(3) of the draft regulation to require that OHTs, as a precondition of designation, have representation in the form of constituent members from all services set out in section 29 (1) of the Act, with the addition of public health.

Amend section 2(3) of the draft regulation to require that the "description of how the proposed Ontario Health Team intends to provide, in an integrated and co-ordinated manner" all services set out in section 29 (1) of the Act include, at a minimum, the following:

**Care co-ordination and planning**

- Strategies to improve access, co-ordination and communication for patients, families and caregivers.
- An engagement strategy to facilitate partnerships with patients, families, caregivers and communities.
- A plan to facilitate co-ordination of care within the OHT, to support seamless transitions across the system.
- A plan to assess and meet the health-care needs of the OHT's attributed population.

- A plan to expand the number of constituent members within the OHT, to ensure it offers a full basket of services, including harm reduction services

**OHT governance and management**

- A governance model, including performance targets and accountability objectives.

- Financial management plan and demonstrated capacity to administer an integrated funding envelope.

- Evidence of a responsible and accountable leadership structure.

**Digital data collection and reporting**

- Demonstrated capacity to collect and report data on key performance metrics and integration indicators, and an ability to analyze the data to plan and mobilize resources for the patient population.

- Implementation of digital health solutions to:
  - securely share patient information among providers,
  - make use of clinical workflows and pathways to optimize care,
  - allow patients to have improved access to health information, and
  - improve population health management, quality improvement and outcome measurement.

**Rationale:**

RNAO supports the requirement to submit a plan for integrated and co-ordinated services to the ministry of health. At present, the Act requires that OHTs only provide "at least three" of the services under section 29(1) as a prerequisite to designation. However, the provincial government's 2019 document entitled *Ontario Health Teams: Guidance for Health Care Providers and Organizations* indicates that, at maturity, OHTs will offer a full and co-ordinated continuum of services to achieve target outcomes, including:

- primary care (including inter-professional care),
- secondary care (i.e. in-patient and ambulatory medical and surgical services (includes specialist services),
- home care and community support services,
- mental health and substance use services,
- health promotion and disease prevention,
- rehabilitation and complex care,
- palliative and hospice care,
- residential care and short-term transitional care (e.g. supportive housing, long-term care homes, retirement homes),
- long-term care home placement,
- emergency health services,
- laboratory and diagnostic services,
- midwifery services, and

- other social and community services as needed by the population.

This would also include care co-ordination and system navigation across these services.

Since dissemination of this guidance document, OHTs have demonstrated the capacity to enlist a far broader spectrum of services than the Act requires as a precondition of designation. The draft regulation should press OHTs to maximize their capacity to integrate and coordinate services.

RNAO expects that the list of services expected of OHTs include **harm reduction services and programming** across the care continuum – at a minimum, supervised consumption, safer supply and drug checking services.

### Recommendation 7: home care "readiness and delivery plan"

Amend section 2 (3) ii. of the regulation to require that the "readiness and delivery plan" for home and community care include the following details as a precondition of OHT designation:

- Measures that the OHT constituent members will take to improve integration and co-ordination of the home and community care sector within the broader health system.

- Specific steps that home care providers will take to ensure clients do not experience service interruptions as a result of the structural changes to the system from Bill 135.

- A plan to make use of care co-ordination/system navigation, anchored in primary care, to facilitate access to and integration of home and community care services (RNAO, 2012a; RNAO, 2012b; RNAO, 2014; RNAO, 2020a; RNAO, 2020b; RNAO, 2023b; RNAO, 2024b; RNAO, 2024c).

- Measures to ensure funds saved from increased integration, care co-ordination and better outcomes are re-invested into additional access to home care services for Ontarians and not to profit-making (RNAO, 2020a; RNAO, 2020b).

- Measures to ensure OHTs are accountable to needs-based funding that follows patients in an efficient and person-centred manner, adjusting for personal circumstances (RNAO, 2020b).

- A strategy to make use of digital health technologies as part of OHT integration activities (RNAO, 2020a; RNAO, 2020b).

- A health human resource strategy and integration plan to bolster the home and community care workforce to meet the home care needs of the attributed population (RNAO, 2020a; RNAO, 2020b; RNAO, 2023b).

**Rationale:**

OHTs should submit a home care readiness and delivery plan to the health minister as a precondition of designation. Additionally, the ministry of health consultation paper regarding the proposed new regulation under the Act indicates: "The ministry, with support from partners, will develop a template to support the development of this plan." This template should be subject to a public consultation process, to ensure the required contents of home care readiness plans are sufficient to guarantee high-quality care.

Although OHTs must be held accountable to providing high-quality integrated home care, the ministry of health must also play a significant role in the modernization of the home care system. The ministry must:

1. Update the funding model for home and community care services:

   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 (RNAO, 2012b; RNAO, 2014; RNAO, 2020a; RNAO, 2020b; RNAO, 2023b; SE Health et al., 2022) An updated model must fund baskets of services to allow a person-centred approach that encompasses a range of nursing interventions, including health education and teaching, treatment, rehabilitation, health maintenance, social adaptation and integration, support for the family caregiver, and end-of-life and palliative care (RNAO, 2012b; RNAO, 2014; RNAO, 2020a; RNAO, 2020b; RNAO, 2023b). Funding packages should be provided to expand access to home and community care services in equitable ways, according to individual patient/client needs (RNAO, 2020a; RNAO, 2020b).

2. Facilitate the provision of home and community care directly through OHTs and health service providers:

   Bill 135 will allow for the dissolution of Home and Community Care Support Services (HCCSS)/ Local Health Integration Networks (LHIN), transitioning the provision of home and community care to OHTs and client providers. Relocating all care co-ordinators from HCCSSs/LHINs directly into frontline care organizations will help to support integration (RNAO, 2012a; RNAO, 2012b; RNAO, 2014; RNAO, 2020a; RNAO, 2020b; RNAO, 2023b; RNAO, 2024b; RNAO, 2024c).

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

   Contracts should be awarded to providers that can deliver nursing, personal support and rehabilitation services 24/7. The same service provider should provide the entire required service package to a client (RNAO, 2020a; RNAO, 2020b; RNAO, 2023b).

4. Award contracts to home and community care organizations based on quality outcomes and accountability:

   The government must develop standard criteria to ensure the best performing providers who offer evidence-based home and community care services to Ontarians are given preference (RNAO, 2020b). Accountability for service provider organizations must be strengthened by enacting clear policies, performance metrics reporting and auditing. This must also include public reporting requirements (SE Health et al., 2022).

5. Collect comprehensive health human resources data for the home and community care sector:

   Ontario is missing critical data related to health human resources in the home and community care sector. We urge the government to immediately address this issue by identifying and implementing systematic data collection and reporting mechanisms for this sector. Such data is necessary to identify immediate priority staffing needs, and for projecting supply and demand needs for the sector.

In sum, RNAO urges the ministry of health and OHTs to work together to develop a robust HHR strategy and integration plan to bolster the home and community care workforce. This plan must incorporate the following elements:

- Eliminate the outdated pay-per-visit model, as employees in the home and community care sector are forced to seek alternative work during times when service volumes decline and their main employment income drops (RNAO, 2012b; RNAO, 2014; RNAO, 2020a; RNAO, 2020b; RNAO, 2023b; SE Health et al., 2022).
- Adhere to high employment standards, including: salaries and benefits consistent with hospital employees; and full-time employment to foster continuity of care and caregiver and quality of work life (RNAO, 2020a; RNAO, 2020b; RNAO, 2023b).

## Section 3 of the draft regulation

### Recommendation 8: Exemption for OHT integration

Delete section 3 from the draft regulation.

**Rationale:**

Section 35(5) of the Act sets out a list of information to be provided to the health minister along with notice of any proposed integration under this provision. This list includes an analysis of financial implications, service delivery implications, health system implications and/or human resource implications of the proposed integration, where applicable. This is vital information that should remain required as part of each OHT's integration plan, which must be submitted to the health minister prior to receiving designation.

Section 35(5) also requires that:

- OHTs provide a description of any community engagement processes used to consider the proposed integration, with information on and analysis of any issues that were raised in the consultation processes.

- OHTs describe the proposed timing or staging of implementing the proposed integration, as well as a description of the level of approval received by the provider or team within its organization.

These requirements support both underpinning principles of health system transformation - care integration and population management. Retaining these requirements will enhance the consistency, accountability and transparency of OHT maturation. Since OHTs are already required to provide a

"description of how the proposed OHT intends to provide, in an integrated and co-ordinated manner" the types of services it aims to deliver[2], RNAO further recommends that OHTs should be required to include the information as currently required under section 35(5):

"(a) a description of the proposed integration, including the identity of the parties involved with the integration;

(b) the health service provider or OHT's analysis of any financial implications, service delivery implications, health system implications or human resource implications of the proposed integration, where applicable;

(c) a description of any community engagement processes that the provider or team used to consider the proposed integration, and a description of any issues that were raised in those consultation processes, plus the provider or team's analysis of those issues, where applicable;

(d) a description of the proposed timing or staging of the implementation of the proposed integration; and

(e) a description of the level of approval received by the provider or team within its organization."

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[2] Specifically, section 29(1) of the Connecting Care Act outlines the following services: hospital, primary care, mental health or "addictions", home and community care, long-term care home, palliative care, and "any other prescribed health care service or non-health service that supports the provision of health care services".

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