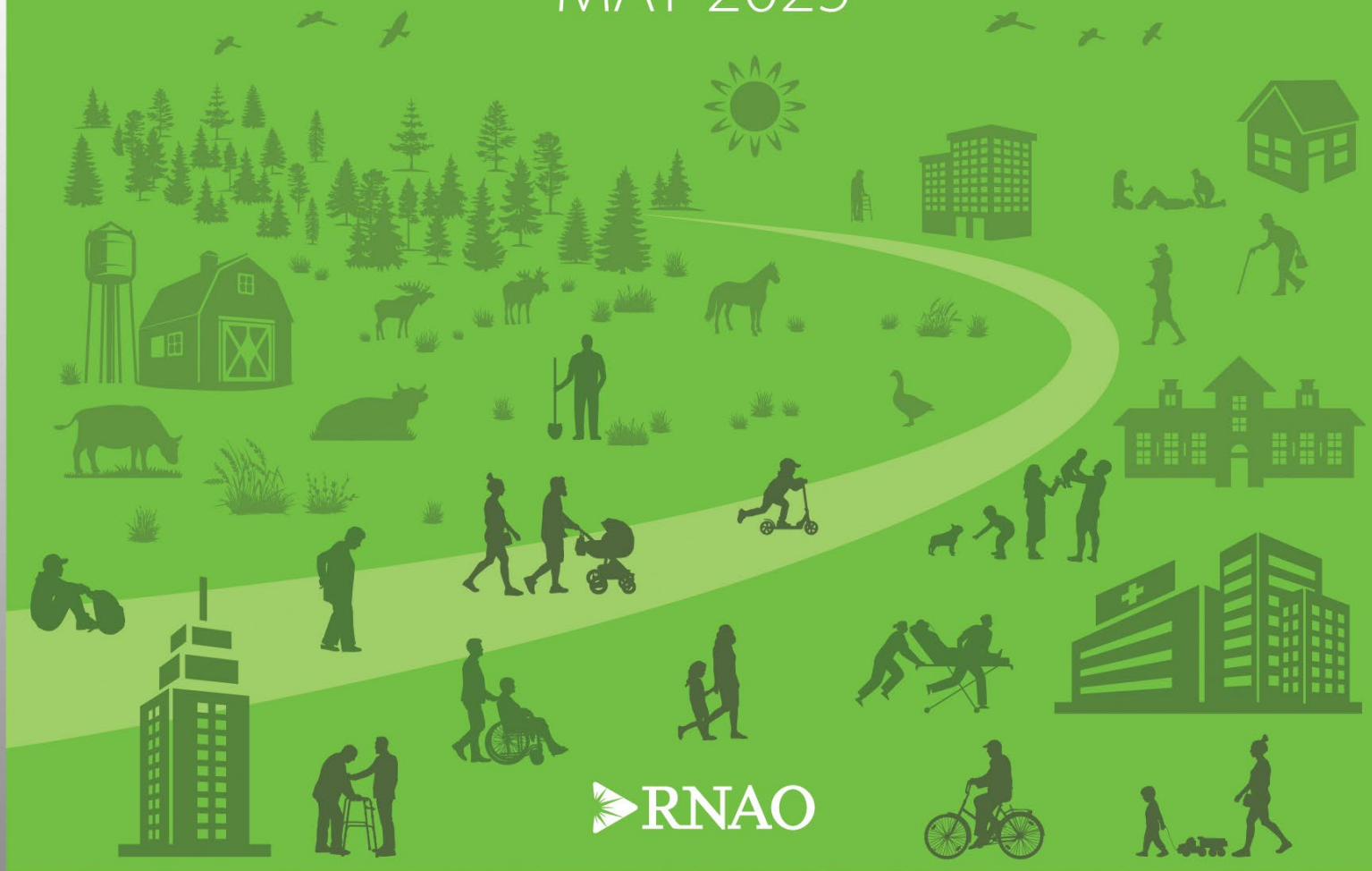
RNAO - ECCO MODEL 4.0

ENHANCING COMMUNITY CARE FOR ONTARIANS

MAY 2025



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Land acknowledgement

We recognize that RNAO's office is located on the traditional and unceded territory of the Huron-Wendat, Haudenosaunee, and the territory of the Mississaugas of the Credit. This territory was the subject of the Dish with One Spoon Wampum Belt Covenant, which is an agreement between the Iroquois Confederacy and the Ojibwe and allied nations to peaceably share and care for the resources around the Great Lakes. We also acknowledge that Toronto is covered by Treaty 13 under the Toronto Purchase Agreement with the Mississaugas of the Credit. Today, this land is still the home to many First Nations, Inuit and Métis peoples from across Turtle Island and we are grateful to have the opportunity to work on this territory. By making a land acknowledgement, we are taking part in an act of reconciliation, honouring the land and Indigenous heritage which dates back more than 10,000 years. We encourage readers to learn about the land where you reside on and the treaties that are attached to it. Land acknowledgements are an act of reconciliation, and we must all do our part.

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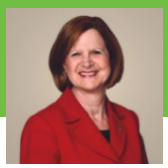

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Message from RNAO's CEO and President

We are proud to share with you the fourth edition of *Enhancing Community Care for Ontarians (ECCO)*. ECCO 4.0 is our renewed and updated call to government and health-system partners to strengthen community care and anchor the health system in publicly-funded primary care shielded from the distortions of profit. We need health care designed to serve **all** – especially the most vulnerable in our province.

RNAO issued its first ECCO report in 2012, which proposed a model of care anchored in primary care and built on the following attributes: accessible, equitable, integrated, person-centred, publicly-funded and not-for-profit.

The need for the ECCO model has endured – indeed grown – in the years since its inception. What has changed, however: The **context** for the ECCO model. While there has been progress, we cannot ignore the serious threats facing our health system. Short-sighted cost-cutting, expanding privatization disguised as "innovation" and investor-driven interests risk eroding our public system from within. These forces undermine the quality, equity, and sustainability of care for Ontarians.

The future of health care in Ontario hinges on the choices we make now. Will we build a system that puts people and their health at the centre – or surrender to a model that leaves too many behind? At this juncture, we face overlapping crises: a critical nursing shortage, overwhelmed hospitals, more than 45,000 people waiting for long-term care, and 2.5 million without access to primary care. Complicating factors include the deeper systemic issues shaping conditions for ill health – climate disruption, unaffordable housing, and widening inequities.

ECCO 4.0 meets this moment. It offers 16 recommendations for a renewed and expanded blueprint for transformation – one that is strategic and grounded in real-world conditions. Most importantly, this edition places equity, diversity and inclusion (EDI) at the heart of system design. Because when health care fails, it fails the most vulnerable first.

The pandemic exposed this reality. First, the virus ravaged Ontario's ill-prepared long-term care facilities, leaving seniors to die alone. Then we learned of the harsh impacts falling on racialized communities, Indigenous Peoples and low-income populations. How we respond is our litmus test. EDI cannot be an afterthought – it must be embedded into every policy, every reform, and every act of care, if we are to build a system that truly deserves to be called "universal."

We invite you to engage with this report. There is enormous potential for good - and much at stake. Our health system is more than its infrastructure. It reflects who we are and what we value as a society. It is part of the social contract that binds us. If we do not protect it, we risk losing it – for ourselves and for future generations.

To RNAO's board of directors, and to the many nurses and other health professionals who contributed to this report – thank you. Together, we call for action rooted in the needs of all who call Ontario "home".

Executive summary

Introduction

This report is the fourth in a series of RNAO reports calling for "enhanced community care for Ontarians" (ECCO). In 2012, RNAO issued its original ECCO report, which proposed a model of care anchored in primary care and built on the following attributes: accessible, equitable, integrated, person-centred, publicly-funded and not-for-profit.[1] The need for the ECCO model has endured – indeed grown – years since its inception.

RNAO issued ECCO 2.0 in 2014 with an updated human resources transition plan.[2] Eric Hoskins, while serving as Ontario's Minister of Health, recognized ECCO 2.0 as a key document that influenced his 2015 action plan for better health care.

Released in 2020, ECCO 3.0 was a response to the Ontario government's then-recently launched health system transformation (HST) agenda, which included the creation of Ontario Health, and the initiation of an integrated care-delivery system made up of dozens of local, territorially defined Ontario Health Teams (OHT).[3] HST renewed RNAO's hope that reforms would focus on enhancing community care in the province as a means of providing services and improving health outcomes for everyone. The concept of OHTs had many ECCO-like elements.

What changes over time – and prompts successive revisions to the report – is the context for the ECCO model. Each ECCO report grounds the model in real time and place. So long as Ontario's health system continues to constrain and misallocate resources, ECCO reports will remain a continuing RNAO policy initiative needed to offer real solutions to real challenges.

ECCO 4.0 is an urgent call for action. Released more than five years after ECCO 3.0 and more than six years into Premier Doug Ford government's HST process – and in the wake of the COVID-19 pandemic – it situates Ontario at a crossroads. HST remains a policy with promise – as suggested by early exemplars of system integration outlined below – but its roots in expenditure management remain deeply concerning. The pandemic exposed the fragility of our health system, the insufficiency of our social support system and the urgent need to ensure that equity, diversity and inclusion are hallmarks of Ontario society, not just aspirations.

[1] Registered Nurses' Association of Ontario (RNAO), "ECCO: Enhancing Community Care for Ontarians – A Three Year Plan (White Paper)."
[2] RNAO, "ECCO 2.0: Enhancing Community Care for Ontarians – A Three Year Plan."
[3] RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians."

ECCO 4.0 makes clear what path we are on at present – one that appears to be moving away from the goal of equitable and universal health coverage for all Ontarians. It also identifies a better path – one we must take. This path leads to the ECCO model and a place where health is a resource for everyday living, where health care is a universal human right and where human dignity is a lived value.

We set out this path in the form of a series of recommendations. The A-series and B-series recommendations adapt the ECCO model to reflect changes in the health system since the last iteration of the report. They update the ECCO model by sector and across sectors, respectively, and each includes the underlying rationale, updated action items for implementation, and updates on government policy and system exemplars.

The C, D, and E-series recommendations address matters external to the ECCO model, ensuring that the broader context is at least hospitable to ECCO's success. The C-series addresses the nursing crisis – recognizing that nurses are the backbone of Ontario's health system, and without adequate nursing care, health outcomes for Ontarians cannot improve. The D-series addresses health system transformation, emphasizing that in the pursuit of "better value" for health-care dollars, no one should be left behind. The E-series focuses on key determinants of health, recognizing that current social and environmental public policies in Ontario threaten to overwhelm the health system.

Current context

Health system transformation

RNAO views Ontario's HST efforts as both a potential pathway to realizing the ECCO model and a product of competing government priorities. Although introduced to address fragmented and poorly coordinated care, HST has also been shaped by the government's focus on expenditure management. Emerging from Ernst & Young's (EY) 2018 review [4], HST aimed to consolidate Ontario's health-care transfer payments and promote integration through Ontario Health and Ontario Health Teams (OHTs) – envisioned as local, collaborative networks accountable for delivering comprehensive care to defined populations. The transformation was formalized in 2019 with Bill 74, The People's Health Care Act [5], which legislated this integrated care model.

[4] Ernst & Young LLP (EY), "Managing Transformation: A Modernization Action Plan for Ontario."
[5] "Bill 74, The People's Health Care Act, 2019 - Legislative Assembly of Ontario"; "RNAO's Response to Bill 74: *The People's Health Care Act*, 2019."

While HST promised to improve community-based care and deliver "better value," RNAO remains concerned that cost containment continues to undermine the goal of building a fully integrated, person-centred, and equitable health system aligned with ECCO principles.

Although HST has progressed since 2019, its development remains uneven and incomplete. OHTs have been established in 58 regions, and the government has clarified expectations, notably through *The Path Forward* guidance document.[6] Positive steps include plans for 12 OHTs to lead home care integration by 2025 and the creation of Ontario Health at Home to consolidate home care coordination under one provincial agency.

Significant challenges persist. OHT designation criteria – including establishing not-for-profit coordinating corporations, patient advisory councils, and primary care networks (PCN) – have been outlined but remain largely unmet. Crucially, a transparent, integrated funding model has yet to be implemented. RNAO is also deeply concerned that Bill 60[7] – which expands the provision of care for profit – threatens HST's core objectives by introducing financial motives that conflict with both ECCO principles and the government's stated goals of integration and value. Thus, while RNAO supports HST's vision in principle, it calls for urgent course corrections to realize its potential and prevent worsening inequities and inefficiencies in Ontario's health system.

Looking back: Impact of the COVID-19 pandemic

The COVID-19 pandemic exposed and deepened longstanding weaknesses in Ontario's health system, highlighting the consequences of underfunding, workforce shortages, and neglect of community care. Rather than advancing health system transformation toward integrated, community-based care, the pandemic often sidelined critical sectors like primary and home care, leaving overburdened hospitals to serve as the system's default backstop.

Primary care, central to the ECCO model, was particularly strained. Even before the pandemic, 1.8 million Ontarians lacked a regular primary care provider – a number that grew to 2.5 million by late 2024 and is projected to reach 4.4 million by 2026. Home care and LTC also faltered: LTC homes became epicentres of COVID-19 deaths, accounting for 84 per cent of Ontario's fatalities, while home care remained under-resourced and fragmented.

The pandemic's impact was deeply inequitable, falling hardest on racialized groups, Indigenous Peoples and low-income populations, who faced greater risks and barriers to care. Structural inequities, including anti-Black and anti-Indigenous racism and socio-

[6] Ontario Ministry of Health, "Ontario Health Teams - The Path Forward."
[7] "Submission to the Ministry of Health on Regulations Related to Bill 60, Your Health Act, 2023."

economic disparities, worsened outcomes, underscoring the urgent need for a system grounded in equity, diversity, and inclusion (EDI).

Ultimately, the pandemic revealed a hospital-centric system incapable of meeting population health needs, especially for the most vulnerable. RNAO argues that these lessons must drive Ontario toward a reformed system based on strong, accessible, and integrated community care – one that addresses both the clinical and social determinants of health, as envisioned in the ECCO model.

Current state of community care delivery: Key indicators

Ontario's health system remains fundamentally misaligned – overly reliant on hospitals while chronically underfunding community care. The consequences of this imbalance, worsened by the COVID-19 pandemic, are evident across the system and are undermining timely, appropriate, and person-centred care.

Hospitals: Ontario's hospitals are overwhelmed and over capacity, with the crisis of hallway health care reaching unprecedented levels. Patients are routinely treated in unconventional spaces such as emergency department corridors. Nearly one in five hospital beds is occupied by patients awaiting alternate levels of care (ALC), many of whom should be receiving care in LTC or home care. Emergency department wait times have soared to over 20 hours on average, far exceeding pre-pandemic levels. The chronic failure to invest in primary care, home care, and LTC leaves hospitals to absorb the burden of a system that fails patients upstream.

Primary care: Primary care – the cornerstone of an equitable, high-functioning health system – is increasingly fragmented and inaccessible. 2.5 million Ontarians lack a regular primary care provider, a figure expected to exceed 4.4 million by 2026. Even those with a provider face long waits, with only one-third able to get same- or next-day appointments. Poor continuity of care is a major issue, with only one in four patients receiving follow-up within a week of hospital discharge. These gaps are felt most acutely in racialized and low-income communities, where disconnection from primary care is highest. Without robust primary care, people turn to emergency departments, driving up costs and worsening outcomes.

Long-term care: Ontario's LTC sector is unable to meet growing demand, with over 45,000 people on waitlists – a number set to rise as the population ages. Limited LTC capacity forces patients to remain in hospitals, contributing to the ALC crisis and blocking acute care beds. Staffing shortages and limits on nursing scope of practice further impede timely, appropriate care. As a result, avoidable emergency department visits from LTC homes are increasing.

Addressing this requires urgent system reform, including expanding RN prescribing and ensuring nurse practitioners (NPs) are present in nursing homes.

Looking ahead: A population health approach required

Ontario's health system cannot be sustained without adopting a population health approach that focuses on preventing illness and addressing the social determinants of health. With the population aged 65 and over expected to grow by 60 per cent by 2040, and chronic illness rates rising sharply, Ontario risks a future where more people live longer in poor health – unless decisive action is taken.

To reverse this trend, Ontario must strengthen partnerships between public health, primary care, and social services to prevent and manage chronic disease and invest in the social and economic factors that shape health, including poverty, housing, and food security. Yet, Ontario continues to spend less per capita than other provinces on both health care and social supports, leaving many communities without the resources they need to stay healthy.

Marginalized groups – including Indigenous, Black, and 2SLGBTQI+ communities – face higher rates of poverty and chronic disease, underscoring the need to embed EDI into all health system reforms.

Ultimately, achieving better health outcomes for all Ontarians requires integrating health care with social services and committing to upstream action that prevents illness before it starts. Without these steps, Ontario will remain trapped in a costly cycle of treating preventable illness.

Equity, diversity and inclusion

Equity, diversion and inclusion (EDI) must be central to Ontario's health system transformation. Achieving health equity means eliminating unfair and avoidable differences in health outcomes, ensuring that everyone – regardless of race, income, gender, or other identity factors – can access the care they need.

Systemic inequities, including anti-Indigenous and anti-Black racism, poverty, and social exclusion, continue to create barriers to care and worsen health outcomes, particularly for marginalized communities. Ontario Health's "EDI and Anti-Racism Framework" provides a foundation for action[8], but meaningful change requires system-wide commitment and accountability.

RNAO emphasizes that EDI is both a moral imperative and essential for a more effective and sustainable health system. Integrating EDI into health system transformation will improve

[8] Ontario Health, "Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework."

access, quality of care, and outcomes for all Ontarians – especially for those most at risk of being left behind.

Recommendations

The foundations of the ECCO model

The ECCO model envisions an integrated health system anchored in strong community care, led by primary care, and grounded in five core principles: *accessible, equitable, person-centred, integrated,* and *publicly funded* and *not-for-profit*.

At its heart, ECCO calls for every person in Ontario to be attached to primary care through a family physicians or nurse practitioner that work in interprofessional primary care teams to provide comprehensive, continuous care and serve as the central hub for coordinating services across the system. The model emphasizes equity, requiring outreach to marginalized populations and accountability for reducing health disparities. It is person-centred, prioritizing care that respects individuals' unique needs, experiences, and goals. Integration is essential, ensuring smooth transitions and coordination across sectors, with primary care teams leading care planning and navigation. Finally, ECCO insists on public funding and not-for-profit delivery to ensure high-quality, equitable, and cost-effective care for all Ontarians.

The ECCO model offers a clear blueprint for transforming Ontario's health system to improve health outcomes, advance equity, and ensure sustainability.

The following table presents a summary of all recommendations (A–E series) that together form the foundation of the ECCO model. These recommendations outline the sector-specific and system-wide actions needed to create an integrated, person-centred, equitable, and sustainable health system for Ontario. Each recommendation is detailed further in the body of the report (starting on page 48), including key action items, rationale, system exemplars, and government action.

Recommendation #	Recommendation summary (page in report)
A. Sectoral	
A1. Public health	Improve population health by aligning public health and primary care (page 53).
A2. Primary care	Expand the reach of and access to primary care to ensure all Ontarians are attached to a primary care team (page 57).

• A2a: Universal reach of primary care	Ensure that everyone is attached to a family doctor or nurse practitioner (NP) and has 24/7 access to urgent, non-emergency care. Prioritize the provision of primary care through an interprofessional team-based model (page 57).
• A2b: Equitable access to primary care	Ensure access to primary care services for everyone, without discrimination or differential treatment. Address barriers to care and the impacts of health determinants through community outreach (page 66).
A3: Home care	Increase access to integrated home and community care services by expanding the publicly funded basket of services. Support and scale home care models within OHTs that promote integration with other sectors (page 70).
A4: Long-term care	Re-imagine long-term care (LTC) as "home" for residents by integrating nursing homes into enhanced community care plans and funding (page 74).
B. Cross-sectoral	
B1: Person-centred care	Establish person-centred approaches to care that prioritize health promotion and disease prevention, and incorporate principles of equity, diversity and inclusion (EDI), and community engagement (page 81).
B2: Integrated and coordinated care	Ensure comprehensive care coordination, based in primary care, is available to all Ontarians 24/7 (page 85).
B3: Evidence-based care	Demonstrate a commitment to evidence-based practice across the health system (page 89).
B4: Digital health	Optimize digital health technologies to improve access, enhance integration and support person-centred care (page 94).
B5: Scope of practice	Optimize the contributions of registered nurses, nurse practitioners and other regulated health professionals by enabling them to work to their full scope of practice (page 98).

C. Nursing careers in Ontario	
C1: Nurse retention and recruitment	Build nursing careers in Ontario by implementing retention and recruitment initiatives, including improved compensation (page 103).
C2: Nurse compensation	Ensure fair compensation for nurses by increasing pay, harmonizing wages upwards to address sector disparities, and aligning with competing jurisdictions (page 110).
D. Health system transformation	
D1: Primary care networks	Strengthen primary care leadership, coordination, and social service integration in OHTs to improve patient care (page 113).
D2: Mental health and addiction networks	Engage mental health and addiction (MHA) networks in OHT planning and decision making (page 115).
D3: Funding to promote the Quintuple Aim	Ensure Ontario Health Teams are funded in ways that advance the Quintuple Aim (page 117): • Improving the patient experience. • Enhancing patient and population health outcomes. • Controlling costs. • Supporting better provider experiences. • Promoting health equity (fair access and outcomes for everyone).
E. Determinants of health	
E1: Fiscal effort and social determinants of health	Increase the fiscal effort of government to address the social determinants of health, with an immediate focus on housing and food and income security, particularly rates under Ontario Works and the Ontario Disability Support Program (page 121).
E2: Environmental determinants of health	Mitigate climate-related impacts and strengthen climate resilience and health equity by advancing a low-carbon economy, accelerating the clean energy transition, and ensuring health system preparedness (page 129).

Conclusion

ECCO 4.0 calls for a transformative and urgent shift in Ontario's health system – from a reactive, hospital-centred model to one that is proactive, equitable, and grounded in community-based, integrated care. This shift must be aligned with a publicly funded, not-for-profit system that serves the health and wellbeing of Ontarians – not the interests of private investors. The time for bold, decisive action is now. Without meaningful reforms guided by the ECCO model, Ontario will continue to face widening health inequities, system inefficiencies, rising costs, and worsening outcomes – especially for those already marginalized and underserved.

In contrast, the ECCO model offers a comprehensive, evidence-informed roadmap toward a more sustainable, inclusive, and high-performing health system – one where every Ontarian can access the care they need, when and where they need it. Anchored in primary care and delivered by interprofessional teams committed to equity, people's centredness, and collaboration, ECCO sets a clear direction for reform.

Ontario must choose this path. The health and wellbeing of current and future generations depend on it.

Introduction

The Registered Nurses' Association of Ontario (RNAO) presents *Enhancing Community Care for Ontarians (ECCO) 4.0* – our updated vision of community care services that better meets the needs of the people of Ontario. At the heart of all four versions of ECCO is an enduring model of a health system, grounded in community and anchored in primary care, that is accessible, equitable, person-centred, integrated and publicly funded, delivered primarily on a not-for-profit basis.

While the ECCO model remains a constant, our reports represent an ongoing dialogue with a health system in continuous flux, punctuated by periodic crises. We point to costly flaws that deviate from the ECCO model's real-time responses to issues of system planning, change and need. We also highlight exemplars in our system and alike-systems across Canada and around the world as proof of concept – evidence of what's possible and sources of hope.

Our reports also represent an ongoing dialogue with a much broader political and economic system in continuous flux. Our recommendations account for and respond to the broad economic and socio-cultural trends that impact what is possible and necessary for federal and provincial health policy in Canada. In particular, the tariffs imposed by United States (U.S.) president Donald Trump and his threats to absorb Canada as its "51st state" highlight the vulnerability of Canadian political and policy sovereignty to American influence.

Of grave concern to RNAO is the possibility of the homophobic, racist and xenophobic cultural policy currently gripping U.S. politics, infecting Canadian political culture through US economic aggression and threats of extra-territorial expansion. Canada is already struggling with a homegrown culture war that continues to undermine access of already-marginalized communities to culturally safe health care and threatening even greater harms.[9] For example, legislation passed in Ontario in September 2024 has denied health-care services to many marginalized populations by closing supervised consumption services and blocking access to other harm reduction services.[10] Such political rhetoric has real consequences for the lives and wellbeing of people living in Ontario.

The ECCO model and ECCO reports 1.0 through 3.0

Over time, successive ECCO reports have offered continual course correction, pointing in a better direction to a model of care that improves health outcomes. ECCO 1.0 was first

[9] See the *Equity, diversity and inclusion* section (page 40) for more information.
[10] Government of Ontario, *Community Care and Recovery Act, 2024*, S.O. 2024, c. 27, Sched. 4.

released in 2012. [11] That first version was discussed with then-Minister of Health and Long-Term Care Deb Matthews, lauded by then-Health Critic for the official opposition, Christine Elliott, and supported by then-leader of the Ontario New Democratic Party, Andrea Horwath. Despite initial praise, there was a lack of movement towards RNAO's vision. RNAO issued ECCO 2.0 in 2014 with an updated human resources transition plan.[12] Eric Hoskins, while serving as Ontario's Minister of Health, recognized ECCO 2.0 as a key document that influenced his 2015 action plan for better health care.

ECCO 3.0, released in 2020, was a response to the Ontario government's then-recently launched health system transformation (HST) agenda, which included the creation of Ontario Health, and the initiation of an integrated care-delivery system made up of dozens of local, territorially defined Ontario Health Teams (OHT).[13] HST renewed RNAO's hope that reforms would focus on enhancing community care in the province as a means of providing services and improving health outcomes for everyone. The concept of OHTs had many ECCO-like elements.

ECCO 3.0 set out nine recommendations meant to ensure that HST developed in a way consistent with the ECCO model. Released five months into the COVID-19 pandemic. ECCO 3.0 captured and highlighted some of the profound and tragic consequences of a health system that has let community care wither in favour of downstream, hospital-centric services. ECCO 3.0 also offered a set of transition recommendations – recommendations that were both time- and circumstance-dependent – to ensure that HST made its way through the pandemic in a manner consistent with the ECCO model. It also included long-term care homes modeled on community-based principles.

The principles of the ECCO model

- **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.

[11] RNAO, "ECCO: Enhancing Community Care for Ontarians – A Three Year Plan."
[12] RNAO, "ECCO 2.0: Enhancing Community Care for Ontarians – A Three Year Plan."
[13] RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians."

- **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 coordinated, 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 requires 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 – OHTs. The OHT model presents an opening 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 – asked since RNAO released its first ECCO report 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 at a lower cost.

Health system transformation

At this juncture – nearly five years on from ECCO 3.0 – RNAO provides an update on our recommendations and identifies new sets of action items associated with each. We recognize and celebrate progress towards enhanced community care and offer recommendations to address those challenges that stand in the way of the ECCO model. Two years after the pandemic's end, we have a clearer retrospective of its impact, highlighting gaps in our health system and social safety net, along with data to illustrate our current challenges.

From the outset, RNAO has seen in HST the opportunity to make the ECCO model a reality in Ontario. Yet, we have always been mindful of, and concerned about, the competing government interests embedded in HST from the outset: expenditure management and a health system that was failing both patients and providers.

In 2018, Ontario's Conservative government began its first term of office committed to managing ballooning (in its view) government expenditures. A government-commissioned review of public expenditures by Ernst and Young (EY) suggested that government had lost control over operating expenditures, pointing to the sheer number of transfer payments made by the government to delivery partners outside the Ontario Public Service.[14] EY identified that for every dollar spent on the Ontario Public Service, nine dollars were spent through the 35,000 separate transfer payments managed by the government. In EY's analysis, the case of "health sector" stood out, representing, at the time, 42 per cent of total government operating expenditures, virtually all in the form of transfer payments.

One can easily find the inspiration for HST in the "modernization action plan" proposed by EY to manage government expenditures.[15] Key to this plan was a reduction of the regulatory burden on government itself and the determination of an "efficient price" for services through consolidation of transfer payment agreements and the imposition of competitive pressures on the consolidated set of delivery partners. Although HST is clearly rooted in the desire to limit health care costs in Ontario, it also takes into consideration health outcomes. The "modernization action plan" was also to provide, alongside expenditure management, a "substantial dividend" in the form of enhanced autonomy and expertise of its delivery partners flowing from reduced government regulation.[16]

In a flurry of activity in early 2019, it became clear how a new approach to government expenditure management was going to materialize in the health sector through health system transformation. The first "interim" report of the Premier's Council on Improving Healthcare and Ending Hallway Medicine (Council) led the way in January 2019.[17] Using hallway health care as the critical symptom of a struggling health-care system, the Council's first report outlined the causes of strain on both patient and provider and pointed to a lack of system capacity and coordination within the system. The report pointed to the opportunity for a substantial dividend – improved health outcomes for less taxpayer money spent – that is, "better value."[18]

[14] Ernst & Young LLP (EY), "Managing Transformation: A Modernization Action Plan for Ontario."
[15] Ernst & Young LLP (EY).
[16] Ernst & Young LLP (EY).
[17] Devlin et al., *Hallway Health Care: A System Under Strain*.
[18] Devlin et al.

In quick succession, the government tabled Bill 74, *The People's Health Care Act*, in February 2019, which issued an "open invitation" to health-care providers to participate in HST and released the Council's second report.[19] Schedule 1 of Bill 74 enacted the *Connecting Care Act* which, in turn, established Ontario Health and introduced the concept of integrated care delivery systems – what we now know as Ontario Health Teams (OHTs). The *Connecting Care Act* implemented the central component of EY's proposed modernization action plan: Establishing a new funding model that would consolidate thousands of transfer payments into a few transfer payments (or potentially, a single payment) to an intermediary funding agency, Ontario Health.

Ontario Health, in turn, would consolidate thousands of transfer payments to a limited number of OHTs, each of them to receive a single, "integrated" funding envelope. In doing so, the act established the conditions to unleash competitive pressure on OHTs to seek, and identify for the government, the "efficient price" of health care in Ontario. This new funding model was informed by a regulatory model that encouraged providers to establish their own means of delivering integrated / coordinated care within OHTs.

The *People's Health Care Act* received royal assent in April 2019, following an "open invitation" from the Ministry of Health and Long-Term Care "to providers across the full continuum of care to come together and demonstrate their readiness to become OHTs – groups of providers and organizations that are clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined geographic population." [20]

The Council, through its second report released in June 2019, offered a path to the "substantial dividend" for providers and patients from the government's plan for managing health-care expenditures.[21] The Council put forward a vision that looked remarkably like ECCO: a patient-centred system, with primary care as its foundation and a "modernized" home care sector to improve and enhance community care.[22] The system was to be integrated to ease patient and provider navigation, and coordinated with social services to better address determinants of health.

The following text box outlines key points about Ontario Health and the Ministry's vision of OHT.[23]

[19] Devlin et al., *A Healthy Ontario: Building a Sustainable Health Care System*.
[20] Government of Ontario, "Ontario Health Teams."
[21] Devlin et al., *A Healthy Ontario: Building a Sustainable Health Care System*
[22] Devlin et al.
[23] Ontario Health, "Ontario Health Teams"

The institutional setup of health system transformation

Ontario Health is a government agency created to oversee health care planning, delivery and modernization across Ontario. Its activities include:

- Measuring and reporting on health system indicators.
- Overseeing the delivery and quality of clinical care services.
- Managing aspects of health system funding and accountability.
- Setting quality standards and developing evidence-based guidelines.

In the context of health system transformation, Ontario Health's mandate is to work with the Ministry of Health, the Ministry of Long-Term Care, and Ontario Health Teams (OHT) to advance the **Quintuple Aim** by providing:

- Strategic guidance for OHTs based on MOH policy direction, and supporting OHTs in implementation efforts.
- Regional support for OHTs such as coaching, partner collaboration, conflict resolution, alignment with health system strategies, and knowledge transfer.
- Strategic management of OHT accountability agreements.
- Oversight for OHT performance and quality improvement.
- Coordination for OHT engagement and communications.

The Quintuple Aim:

- Improved patient experience.
- Improved patient and population health outcomes.
- Lower cost of care.
- Improved provider experience.
- Advancing health equity.

OHTs are meant to organize and deliver health services in local communities, with the goal of providing Ontarians with care that is more convenient and better connected. Providers from health and community sectors work as a collaborative team to form OHTs, sharing resources and coordinating care.

There are currently 58 Ministry-approved OHTs. As per the Connecting Care Act, 2019, the following providers can be part of OHTs, with a requirement for at least three of the following types of services:

- Hospital services.
- Primary care services.
- Mental health or addictions services.
- Home and community care services.
- Long-term care home services.

- Palliative care services.
- Any other prescribed health-care service or non-health service that supports the provision of health care services.

HST progress to date

The government is still far from proving the concept. Since 2019, through amendments to the *Connecting Care Act*, new legislation and regulation, HST has aligned with the vision in the Council's second report. And, in 2022, the Ministry released "The Path Forward", a guidance document to support OHTs in their paths to maturity.[24] The document outlines expectations for OHTs related to clinical priorities, governance, operational capacity, and communications.

OHTs have evolved in clarity and purpose through successive iterations of policy documents. Yet, progress toward integrated care has been uneven. In response, the government announced in autumn 2023 that an initial group of 12 OHTs would be supported to advance to maturity by accelerating home care delivery in their local communities, starting in 2025. The initial goal is for these teams to seamlessly transition people experiencing chronic disease through the health system.

Other significant recent developments include:

- **Collapse of Ontario Home and Community Care Support Services (HCCSS) into Ontario Health atHome:** In March 2021, the government announced that Local Health Integration Networks (LHINs) would begin operating under the new name of "HCCSS", with a singular mandate to deliver patient care. At that time, non-patient care functions of LHINs (e.g. health system planning and funding) were transferred to Ontario Health. Subsequently, through the *Convenient Care at Home Act, 2023*, Ontario Health atHome was established as a single agency responsible for coordinating all home care services across the province. This legislation allows for the assignment of Ontario Health atHome care coordinators to work within OHTs and other frontline care settings.
- **Identification of conditions for OHT "designation":** Designation denotes an OHT's readiness to receive an integrated funding envelope and enter into an accountability agreement with Ontario Health. After receiving designation, OHTs can be collectively funded through the funding envelope to provide health and non-health services to patients of OHT members. Recent designation requirements for OHTs include:

[24] Ontario Ministry of Health, "Ontario Health Teams - The Path Forward."

- Creating a not-for-profit coordinating corporation with specified characteristics: Each OHT is required to have a dedicated, not-for-profit coordinating corporation to ensure appropriate governance and decision-making structures.
- Involving patients, families and caregivers: Each OHT coordinating corporation must have an advisory council of patients, families and caregivers, with the chair of the advisory council serving on the board of directors.
- Establishing a Primary Care Network: Each OHT must have a Primary Care Network to: connect, integrate, and support primary care providers; improve care coordination and delivery; and provide a voice for primary care within OHT decision-making structures.
- Demonstrating home care delivery readiness: Each OHT must create and submit a plan describing how the OHT intends to provide integrated and coordinated services, as well as how the OHT plans to provide home care services.

BPSO OHTs

RNAO, encouraged by the ECCO underpinnings of HST, developed a new model of Best Practice Spotlight Organizations® (BPSO®): the BPSO OHT. This model is intended for integrated systems of care in which all the organizations that form an OHT implement best practice guidelines (BPG) as one coordinated team with support from RNAO. All BPSO OHTs implement the *Person- and Family-Centred Care* (2017)[25] and *Care Transitions* (2020)[26] 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. For further details, see *Recommendation B3: Evidence-based care* (page 89).

While HST is progressing, critical policy decisions, such as the funding formula for OHTs, have not been made – or made public – and critical milestones, such as OHT designation, have yet to be reached.

Other legislative initiatives have been counterproductive. Bill 60 (2023), for example, expanded for-profit care in Ontario by allowing for licensing of for-profit surgical clinics. As noted in RNAO's submission to the provincial government regarding Bill 60[27], for-profit care has damaging impacts, including compromised patient safety, limitations on access, higher costs, and health human resource understaffing.

[25] RNAO, *Person- and Family-Centred Care*.
[26] RNAO, *Transitions in Care and Services*.
[27] RNAO, "Submission to the Ministry of Health on Regulations Related to Bill 60, *Your Health Act, 2023*."

Moreover, system integration and the funding formula required to incent integration need to be grounded in an ethic of – and the practice of – pooling, sharing and cooperating. The profit incentive conflicts with this ethic and undermines such practices, coming into direct conflict with RNAO's recommendation with respect to the OHT funding formula.

RNAO notes that the Quintuple Aim precludes the expansion of for-profit care in Ontario and requires the suppression, and ultimately elimination, of profit extraction from the health system. All segments of the Quintuple Aim are undermined by incursion of profit incentives within the health system. Moreover, both fundamental objectives of HST – expenditure management and integrated care – conflict with profit extraction and profit incentives, respectively.

Changing circumstances, and a close eye on HST, have prompted us to add new recommendations to ECCO 4.0. RNAO offers a fulsome set of recommendations to deal with circumstances and challenges as they present in 2025. In the wake of the pandemic, ECCO 4.0 focusses – more than its predecessors – on equity, diversity and inclusion (EDI). HST, we argue in the pages to come, must keep expanding its commitment to integration and population health. This requires that all institutions, programs and services address the social and environmental determinants of health. HST must be motivated by the same belief that informs ECCO and all that RNAO does – that health is a resource for everyday living and that health care is a universal human right.

Over the last two years, health system transformation has accelerated in the wake of the pandemic. Most certainly, opportunities for the system to hew more closely to its own principles and the ECCO model have been missed due to the challenges posed by COVID. We urge the government to recapture these opportunities – it is never too late to improve Ontario's health system. We anticipate that change will continue apace, and we urge the government to follow our recommendations. Ontarians and their health-care providers deserve no less from their government.

Looking back: Impact of the COVID-19 pandemic

In early 2020, COVID-19 plunged Ontario into a vastly different context than the one in which HST was conceived. RNAO's ECCO 3.0 report, released in May 2020, provided an early look at the pandemic's impact, the health system's capacity, and government policy responses.[28]

Five years after ECCO 3.0, the anticipated "substantial dividend" anticipated from HST remains elusive. The pandemic amplified existing vulnerabilities in an already underfunded

[28] RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians."

and understaffed health system. The ECCO model offers solutions for how HST can evolve, building on the lessons learned during the pandemic.

Ontario's long-standing practice of limiting fiscal capacity – an approach that contributed to HST and the push for "better value" – is now an escalating concern. Times have changed. Pre-existing cracks in the system impacting the health workforce, long-term care (LTC) residents and marginalized groups have become daily headlines – issues RNAO has long warned about.

The health-care workforce crisis: The pandemic severely impacted the health-care workforce across all sectors of the system, thrusting an understaffed system into a full-blown health human resource crisis. Ontario's primary care sector – central to the ECCO model – was left in dire straits. The number of Ontarians without a regular primary care provider increased from 1.8 million pre-pandemic to 2.5 million by November 2024, and is expected to reach 4.4 million by 2026.[29] See section C, *Nursing careers in Ontario* (page 103) for details on the pandemic's impact on nurses.

The catastrophe in LTC: As noted in ECCO 3.0, COVID-19 in Ontario emerged as a tale of two pandemics: one focused on transmission in congregate settings (such as LTC homes), and the other on community transmission. LTC facilities faced immediate crisis, with 84 per cent of lives lost to COVID-19 during the first phase attributed to residents of Ontario LTC facilities.[30] Issues of overcrowding, low staffing and poor emergency preparedness had long been highlighted by RNAO.[31] While the COVID-19 death rate in Ontario's nursing homes would subside somewhat over the course of the pandemic, it remained significantly higher than international comparators, underscoring the need for deep reforms to ensure safe and effective care in the province.[32]

Over-reliance on hospitals to contain community transmission: The fight to contain COVID-19 transmission in the community focused, paradoxically, on the hospital sector. With the promise of keeping hospitals financially whole, the government turned to the sector to "backstop" the health-care system and provide public health and LTC supports.[33]

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[29] Ontario College of Family Physicians, "New Data Shows There Are Now 2.5 Million Ontarians Without a Family Doctor."
[30] RNAO, "Long-Term Care Systemic Failings: Two Decades of Staffing and Funding Recommendations"; "Nursing Home Basic Care Guarantee: RNAO Submission to the Long-Term Care Staffing Study Advisory Group"; "Submission to the Standing Committee on the Legislative Assembly Re Bill 37.
[31] RNAO, "Long-Term Care Systemic Failings: Two Decades of Staffing and Funding Recommendations"; , "Nursing Home Basic Care Guarantee: RNAO Submission to the Long-Term Care Staffing Study Advisory Group"; "Submission to the Standing Committee on the Legislative Assembly Re Bill 37."
[32] Rocard, Sillitti, and Llena-Nozal, "COVID-19 in Long-Term Care."
[33] Ontario Hospital Association, "Submission to the Standing Committee on Finance for Pre-Budget Consultations in Advance of the 2021 Budget."

Hospitals paid the price of insufficient capacity in community care such as home care and long-term care, and bore the burden of the lack of mental health services in the community. As noted by the Ontario Hospital Association (OHA) in their 2021–2022 pre-budget submission, "hospitals and the health care system entered the pandemic in a state of under-capacity and misaligned resources and services".[34]

Sidelining of primary care and home care: The call on hospitals to backstop the health-care system during the pandemic, despite years of funding restraint in the context of a growing and aging population, left the sector with an acute financial and staffing crunch and record high levels of alternate-level-of-care (ALC) beds (that is, someone waiting to be transferred to more appropriate care in a different setting). Primary care and home care were both sidelined through the pandemic. Decades of reliance on private, fee-for-service delivery of primary care in Ontario left the sector disaggregated, unconnected and disorganized through the pandemic. Primary care offices were shuttered and inaccessible for extended periods as many primary care settings attempted to transition to virtual care. Many Ontarians were forced to turn to hospital emergency rooms for primary care, adding to the enormous burden on the hospital sector and hospital workers. The resulting staffing shortages triggered closures of hospital services such as emergency departments and neonatal intensive care units before the pandemic had even reached its halfway point.

The inequitable impact of community transmission: The pandemic also exposed structural and systemic inequities in the health system, leaving already-marginalized communities with even greater barriers to health care and more exposed to future health crises. Clearly, Ontario has not yet broken with a history of anti-Indigenous and anti-Black racism. Prejudicial views on other matters, such as sexual and gender orientation, have also extended into our present and are reflected in the access to and the quality of health care.

Yet, the government has not taken concrete steps to address the inequities that marginalize so many and leave them vulnerable to poor health outcomes. In fact, post-pandemic inflation, food insecurity and homelessness continue to worsen conditions in marginalized communities. This harsh reality underscores the need for any true "transformation" of our health system to address social needs as a foundation for achieving better health outcomes.

Current state of community care delivery: Key indicators

The pandemic exposed our health system as precariously underfunded, understaffed, misaligned and fragile. While the pandemic was officially declared over in May 2023, its impacts have lingered – and in some cases, worsened.

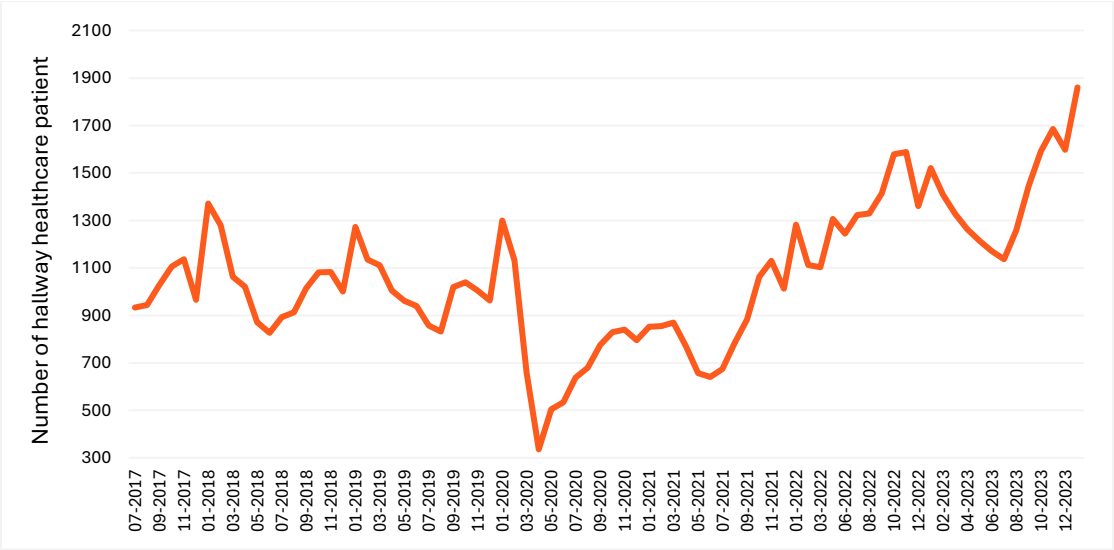
[34] Ontario Hospital Association.

This section provides an overview of the current state of the three core sectors within our community care delivery system and their intersection with acute care, using a few key indicators. In every instance, the detrimental impacts of COVID-19 reflect decades of hospital-centric policy and chronic neglect of community care. The cumulative effect is a severely misaligned health system that has undermined the functioning of our hospital sector.

Hospitals

"Hallway health care" – where patients are forced to wait for a hospital bed in unconventional or unexpected locations, such as on a stretcher in an emergency department corridor – has reached record levels in the post-pandemic period. Even before COVID-19, the report of the *Premier's Council on Improving Healthcare* identified hallway health care as a key reason for pursuing HST.[35] At first glance, hallway health care may appear to be solely a hospital capacity issue. In reality, it reflects a health system overly focused on downstream, acute care – at great and unnecessary expense. It signals upstream deficits in public health and community care, as well as a broader neglect of the determinants of health.[36]

Figure 1: Number of Ontario hospital patients receiving care in unconventional spaces[37]

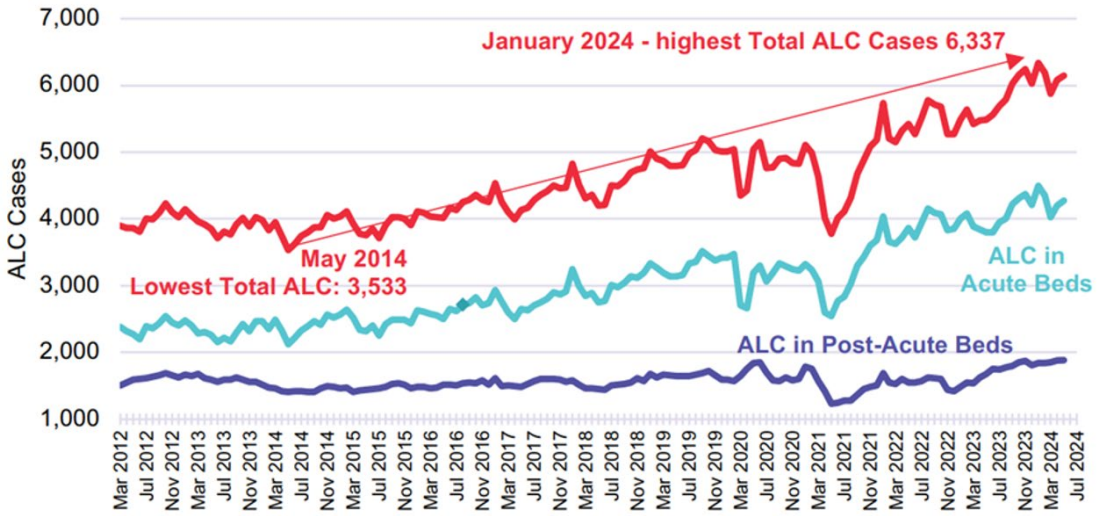


Similarly, hospital ALC beds are an indicator of insufficient capacity in the community sector. As of June 2024, almost one in five hospital beds were occupied by someone who could be receiving more appropriate care in a different setting. Nearly half of the 6,100 ALC

[35] Devlin et al., *Hallway Health Care: A System Under Strain*
[36] Devlin et al.
[37] Chamandy, "Hospital Data Shows Ontario's Hallway Health Care Problem Is Worse than Ever."

patients were waiting for LTC beds. Nearly 700 were waiting for some form of supervised or assistive living.

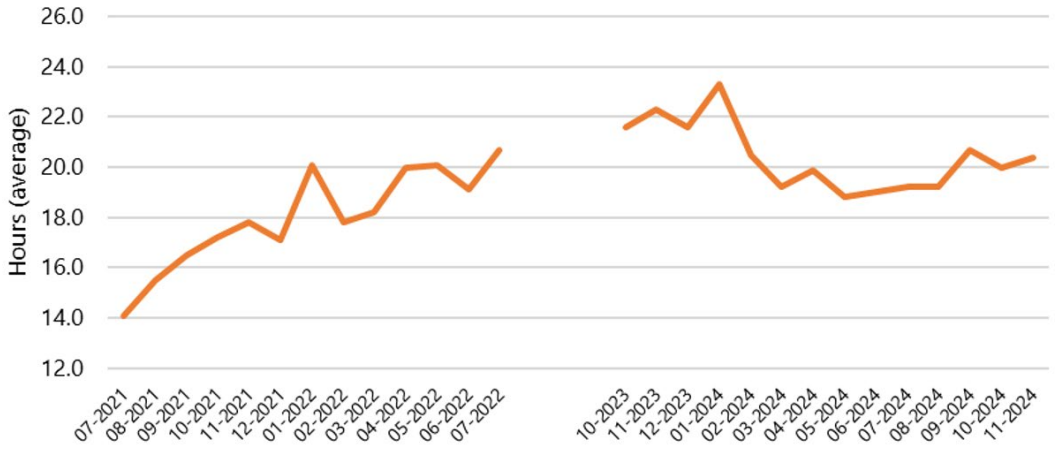
Figure 2: Ontario ALC cases over time (total, acute and post-acute), March 2021–May 2024[38]



Another indicator of insufficient community care is the average length of stay in the emergency department. The longest-ever emergency department wait times were 23.3 hours in January 2024, which further reduced to 20.4 hours as of November 2024. However, these numbers are unacceptably high and still significantly higher than the pre-pandemic levels. Between 2008-09 and 2019-20, the average length of stay in emergency departments for patients admitted to hospitals in Ontario was 15.1 hours.[39]

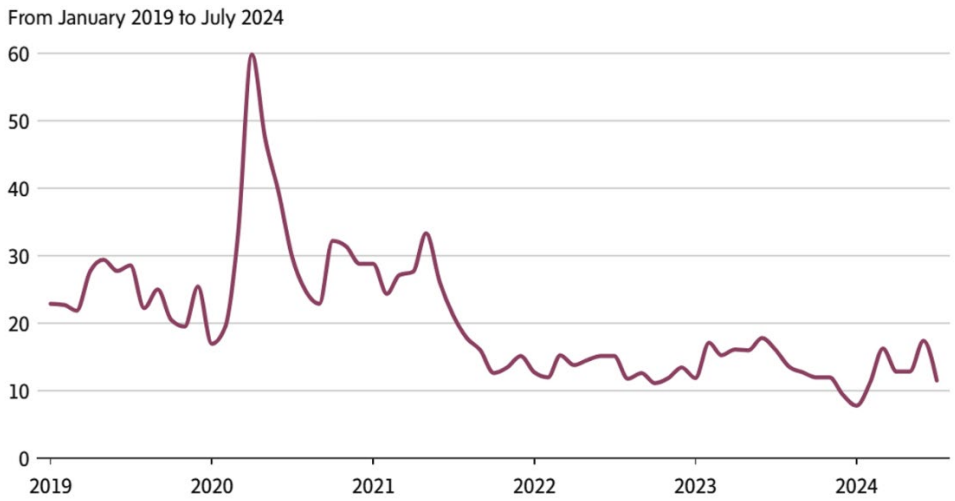
[38] Ontario Hospital Association, "Ontario Hospitals - Leaders in Efficiency."
[39] Financial Accountability Office of Ontario, "Ontario Health Sector."

Figure 3: Average length of stay in emergency departments for patients admitted to hospital in Ontario[40]



This lengthy emergency department stay resulted in a lower percentage of Ontario hospitals that met the provincial target time of eight hours in emergency department for admitted patients. Between January and July 2024, on average, a little over one in eight hospitals met the provincial target time, whereas nearly one in four hospitals were able to meet the target time in the pre-pandemic level.

Figure 4: Percentage of Ontario hospitals that met the 8-hour maximum stay target in emergency for admitted patients[41]



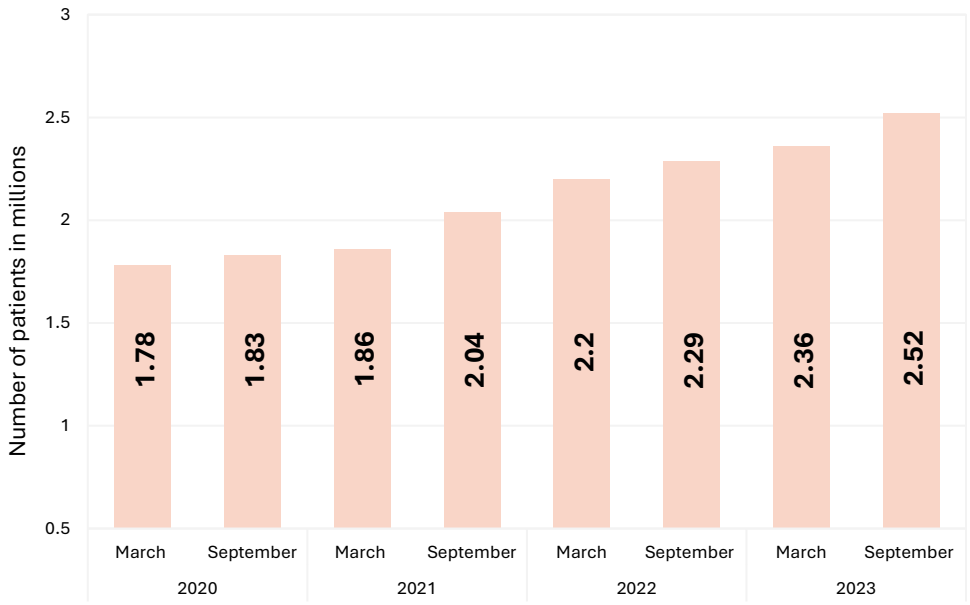
[40] Health Quality Ontario, "Emergency Department Time Spent by Patients in Ontario – Health Quality Ontario."
[41] Ha and Sun, "At Canadian Emergency Departments, Waiting Times Look Grim. But in Many Places, There Is No Data."

Hospitals account for about one-third of Ontario's health-care budget, yet they remain overwhelmed. Many performance indicators continue to decline. Data suggests that health care spending is misallocated between sectors, with disproportionate funding flowing to acute care. A more responsive acute care sector depends on targeted investments in sectors designed to prevent the need for hospital-based care whenever possible. This is the shared purpose of the sectors collectively known as community care – sectors that have long been, and continue to be, under-resourced.

Primary care

The decline in primary care during the pandemic added to the burden on the hospital sector, contributing to backlogs in surgeries and procedures. Primary care entered the pandemic already struggling to fulfill its function within the health system. In 2020, 1.8 million Ontarians were without a regular primary care provider – a group referred to as "uncertainly attached".[42] That number grew to 2.5 million over the course of the pandemic and is projected to exceed 4.4 million by 2026.[43]

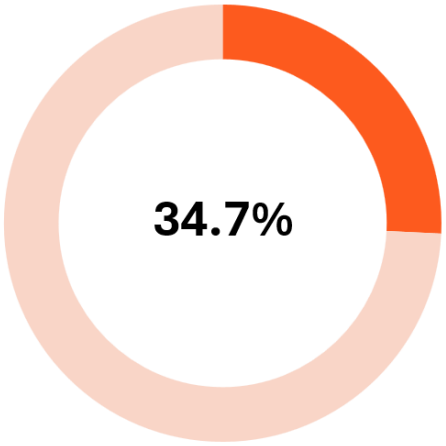
Figure 5: Primary care uncertainly attached rates, 2020–2023[44]



Many Ontarians without a regular primary care provider still struggle to access timely care. Only one-third are able to get a same-day or next-day appointment with their provider.

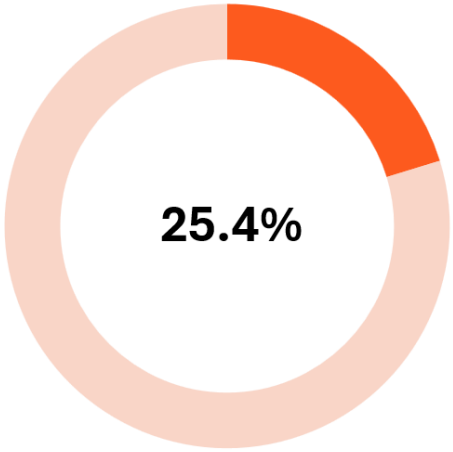
[42] Inspire-PHC, "Primary Care Data Reports."
[43] Ontario College of Family Physicians, "New Data Shows There Are Now 2.5 Million Ontarians Without a Family Doctor."
[44] Inspire-PHC, "Primary Care Data Reports."

Figure 6: Timely access to primary care when sick (same-day or next-day appointment), 2023[45]



Lack of access to primary care also undermines the capacity of the system to provide the right care at the right time in the right place. For example, only one-quarter of patients have a follow-up with their primary care provider within seven days of leaving hospital. This discontinuity of care increases the potential of unnecessary hospital readmissions and places additional burden on the hospital sector for ongoing post-acute care.

Figure 7: In-person patient follow-up with a family doctor after leaving hospital, 2022[46]



The summary data on access to primary care masks significant inequities. Neighbourhoods in Ontario's lowest income quintile and those with the highest racial diversity have the lowest rates of attachment to primary care.

[45] Health Quality Ontario, "Primary Care Performance - Health Quality Ontario."
[46] Health Quality Ontario.

Figure 8: Primary care uncertainly attached rates by income quintile, 2020–2023[47]

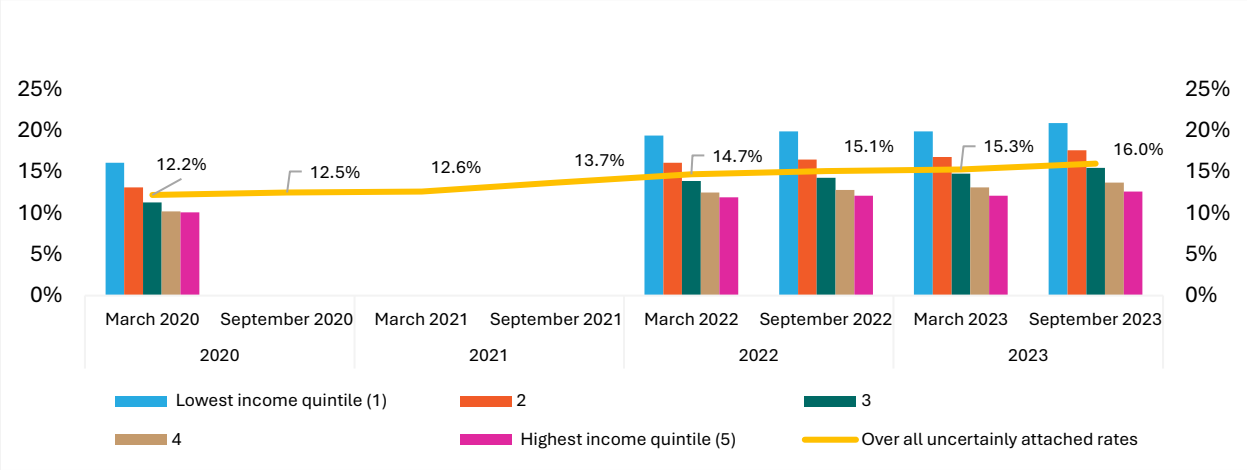
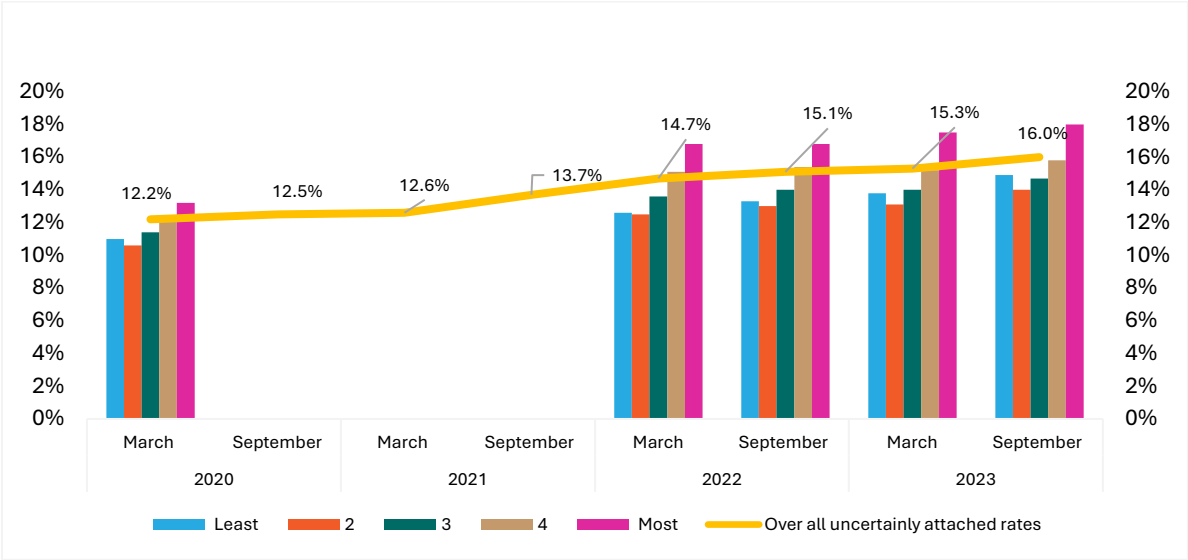


Figure 9: Primary care uncertainly attached rates by racialized and newcomer populations quintile, 2020–2023[48]



Ontario's fractured, inequitable and shrinking primary care sector is the root cause of an increasingly-overwhelmed hospital system. For 16 hours of every weekday and all hours on weekends, Ontarians have virtually no access to primary care, nor to urgent care outside a hospital setting. The health-care needs of Ontarians should not be governed by a "9 to 5, Monday through Friday" business model. For poor and racialized Ontarians, access is even more limited.

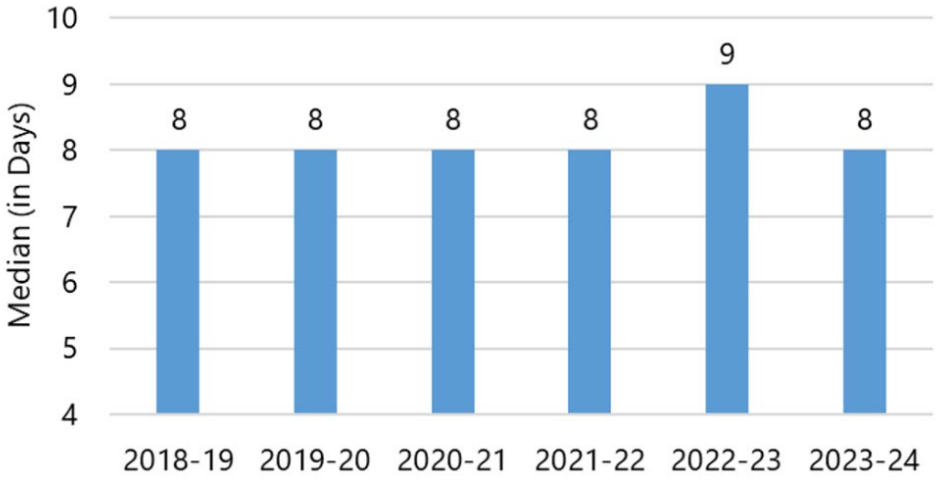
[47] Inspire-PHC, "Primary Care Data Reports."
[48] Inspire-PHC.

The result is not just overburdened emergency rooms. An unavailable and under-resourced primary care sector triggers a vicious circle in health outcomes: opportunities to prevent, diagnose and manage diseases are missed, with the consequent burden of later-stage disease ultimately falling on hospitals. For poorer and racialized communities, it means a deeply compromised right to care and poorer health outcomes than the general population. See *Recommendation A2: Primary care* (page 57) for more information.

Home care

While an increasingly under-resourced primary care sector is largely responsible for over-crowded emergency rooms and hallway health care, an underfunded home care sector also contributes to sustaining these pressures. Although progress is being made on the integration of acute care and home care[49], the median extension of hospital stays while patients wait for home care services has not fallen below eight days since 2018.

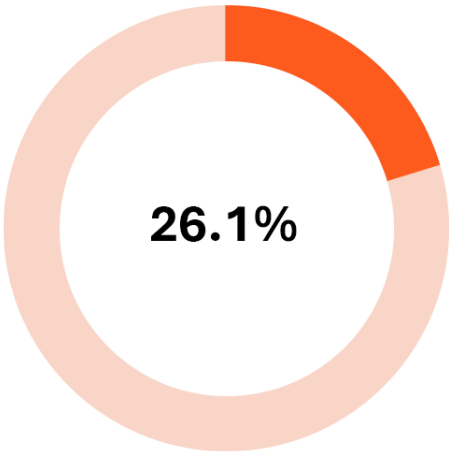
Figure 10: Hospital stay extended until home care services or supports ready (median, in days), 2018-19 to 2023-24[50]



One in four home care patients visit an emergency department within 30 days of hospital discharge, an indication of insufficient post-acute care in the community. Improved access to primary care for these patients could prevent many of these returns to hospital. Greater access to home care would also help alleviate pressure on emergency rooms.

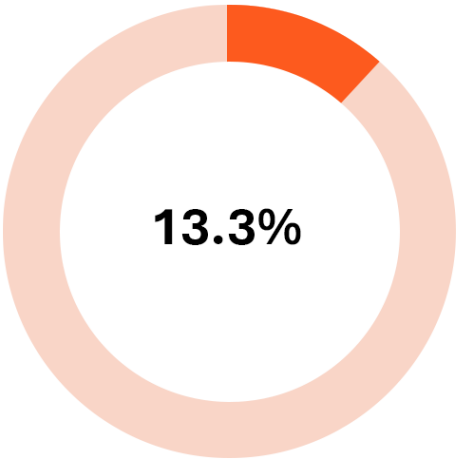
[49] See *Recommendation A3: Home care* (page 70).
[50] Canadian Institute for Health Information, "Hospital Stay Extended Until Home Care Services or Supports Ready."

Figure 11: Emergency department visits by home care patients within 30 days of leaving hospital, 2022–23[51]



More than 13 per cent of home care patients are re-admitted to hospital within 30 days of discharge, further indicating that home care resources are insufficient to meet patient needs.

Figure 12: Home care patients readmitted to hospital within 30 days, 2022–23[52]

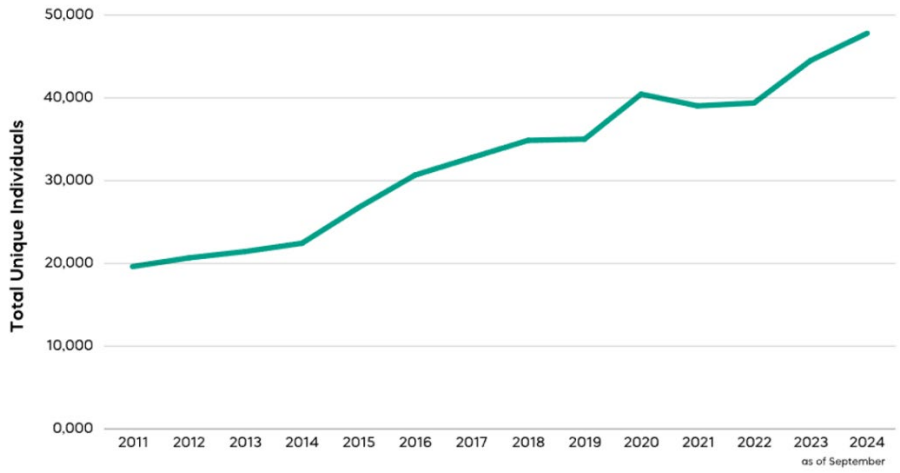


[51] Health Quality Ontario, "Home Care Performance in Ontario – Health Quality Ontario."
[52] Health Quality Ontario.

Long-term care

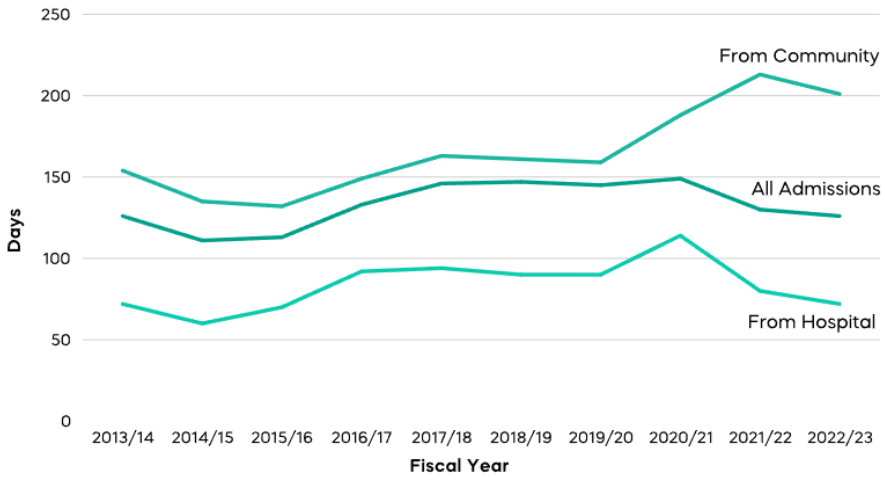
As with home care, an under-resourced long-term care sector significantly contributes to the strain on Ontario's hospitals. Currently, more than 45,000 residents in Ontario are waiting for a bed in a nursing home – a number projected to rise sharply as the population ages.

Figure 13: Total LTC waitlist in Ontario, 2011–2024[53]



Lengthy LTC waitlists result in prolonged waits for beds both from hospitals and, notably, from community settings. The growing wait for a nursing home bed from the community further reinforces the need for a more robust home care sector.

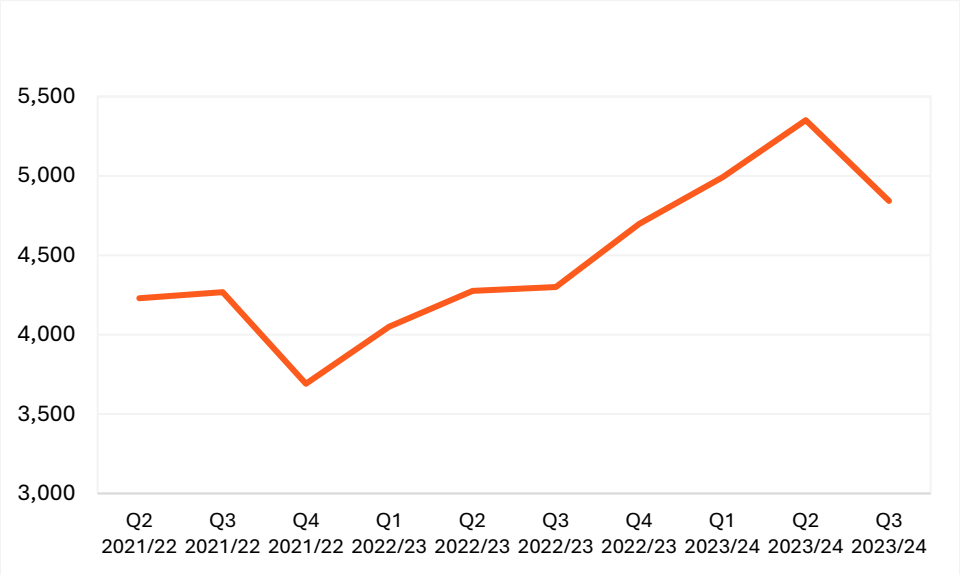
Figure 14: LTC wait times by setting[54]



[53] OLTCA, "The Data: Long-Term Care in Ontario."
[54] OLTCA.

Nursing scope of practice constraints and nursing shortages across primary, home and long-term care all have the effect of over-burdening hospital emergency rooms.[55] Expansion of RN prescribing and the increased prevalence of NPs in Ontario's nursing homes would considerably reduce emergency department visits from LTC residents, which have continued to trend upwards since the middle of the pandemic.[56]

Figure 15: Potentially avoidable emergency department visits for LTC residents[57]



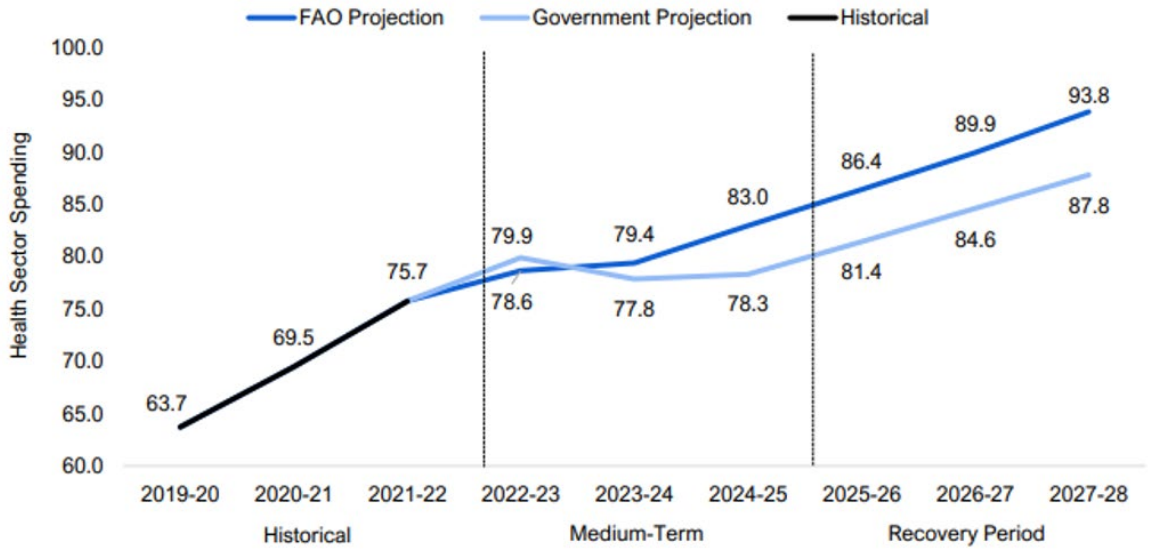
There is an old allegory known as the "river story," often used to illustrate the value of investing health resources upstream. It asks us to imagine a large river with a waterfall. At the base of the waterfall, all resources are focused on frantically saving people who have fallen in upstream. As more resources become available, they are directed to the same task–rescuing people from drowning at the bottom. The ECCO model, like the river story, highlights the importance of investing upstream – in community care – to prevent people from falling into difficulty in the first place.

[55] See *Recommendation A4: Long-term care* (page 74).
[56] See *Recommendation B5: Scope of practice* (page 98).
[57] Ministry of Health; Complex Continuing Care Reporting System (CCRS); National Ambulatory Care Reporting System (NACRS).

Fiscal effort and our health

Ontario's health system – across all sectors and throughout the care continuum – is struggling in the wake of the pandemic. Investments remain insufficient to expand health care capacity and meet growing demand. The Financial Accountability Office of Ontario (FAO) reported in 2023: "Relative to projected growth in demand, by 2027–28, Ontario will have less hospital capacity, similar home-care capacity and less long-term care capacity compared to what it had in 2019–20. From 2022–23 to 2027–28, the Province has allocated $21.3 billion less than will be needed to fund current health sector programs and deliver on its program expansion commitments in hospitals, home care and long-term care."[58] The chart below shows the growing gap between the FAO's estimated spending required to meet these needs and the government's projected spending.

Figure 16: Health sector spending projections, FAO vs. Ontario government, $billions[59]



Indeed, the 2024 Fall Economic Statement projects an expenditure increase of just 0.6 per cent in the current budget year, followed by increases of 2.4 and 2.2 per cent over subsequent budget years. In real terms, health expenditures look to be shrinking and the system contracting.

[58] Financial Accountability Office of Ontario, "Ontario Health Sector."

[59] Financial Accountability Office of Ontario. **Note:** From 2022–23 to 2024–25, the Ontario government projection was taken from the 2022 Ontario Economic Outlook and Fiscal Review. From 2025–26 to 2027–28. Source: Public Accounts of Ontario, 2022 Ontario Budget, 2022 Ontario Economic Outlook and Fiscal Review, and FAO analysis of information provided by the province.

This is clearly true of public health as well. Ontario's pandemic response, including Ontario's health system, was largely supported by $145 billion in direct support measures from the federal government, in addition to nearly $10 billion in federal government cash transfers to the government of Ontario. Ontario's contribution to direct support measures netted out at just 15 per cent of the total. In the wake of time-limited COVID spending, Public Health Ontario – the government agency mandated to prevent and control infections and the spread of communicable disease – found its funding reduced to less than pre-pandemic levels, with a portion of that base funding converted to one-time annual funding.

Figure 17: Public Health Ontario funding, 2018–19 through 2022–23 ($000)[60]

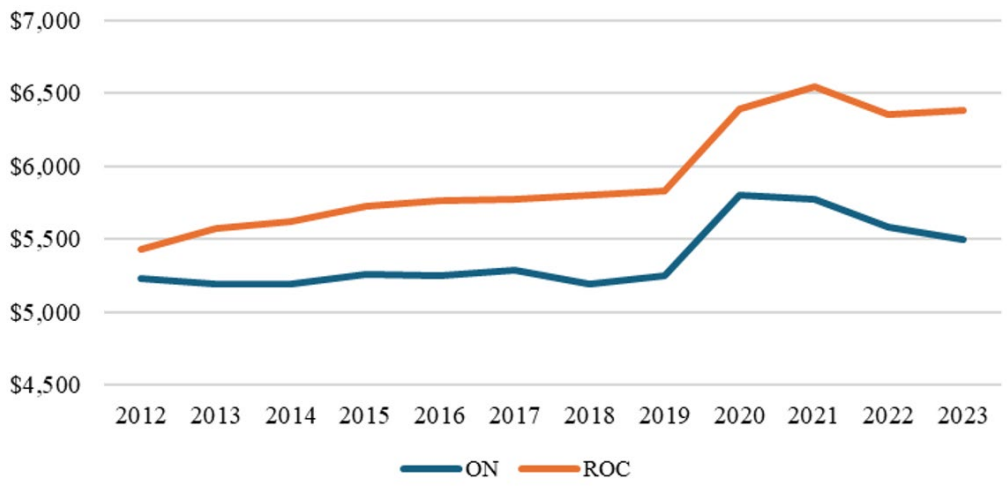
	2018/19	2019/20	2020/21	2021/22	2022/23
Base operations	152,703	156,151	250,480	252,612	205,324
Base funding	152,703	153,114	148,563	151,282	150,683
COVID-19 one-time funding	n/a	3,037	101,917	101,331	54,641

The Auditor-General noted in their 2023 audit, "This lack of consistent funding threatens Public Health Ontario's ability to fully deliver on its mandate and hinders the agency's ability to continue to provide services. For example, the agency has begun to explore options to scale back or dismantle the operations of a committee designed to enhance provincial capacity to respond to public health emergencies" (2023).

Our final chart in this section demonstrates that the systematic and persistent underfunding of Ontario's health system has resulted in the province spending the least per capita in Canada on health care. Moreover, unless a course correction is implemented, this gap will likely continue widening.

[60] Office of the Auditor General of Ontario, "Value-for-Money Audit: Public Health Ontario."

Figure 18: Consolidated provincial-territorial and local governments health spending per capita (constant 2023$)[61]



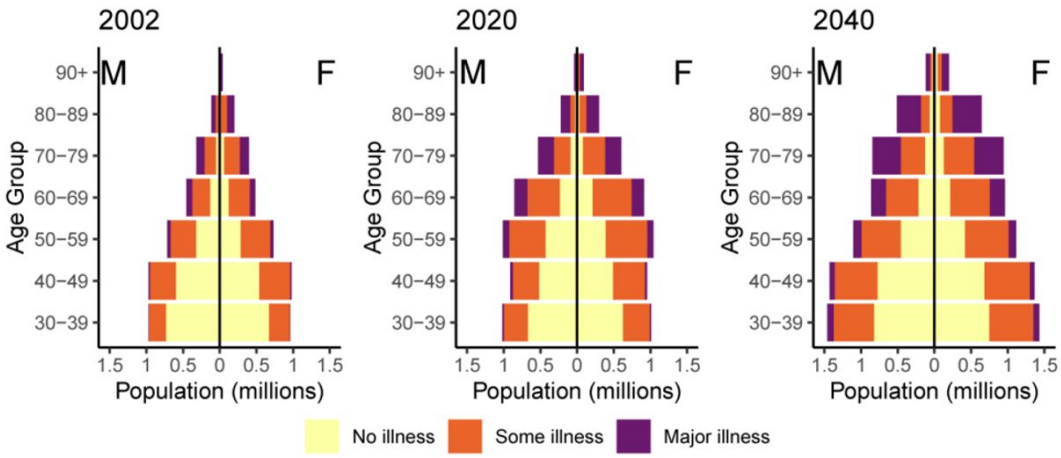
Looking ahead: A population health approach required

The long-term sustainability of Ontario's health system requires a population health approach. This approach aims to improve the health of the entire population while reducing health inequities among groups by addressing a broad range of factors and conditions that influence health.[62]

Current health care trends and projected demographic change highlight this need. Most notably, Ontario's population is aging: by 2040, the number of people aged 65 or older will increase by 60 per cent to 4.2 million, while the population over 85 will grow by more than 150 per cent to 770,000.[63] An aging population will place increasing burden on the health system – pressure that will only intensify if current patterns of chronic disease are not arrested.

[61] Statistics Canada, "Consumer Price Index, Annual Average, Not Seasonally Adjusted"; Statistics Canada, "Canadian Classification of Functions of Government (CCOFOG) by Consolidated Government Component," March 30, 2016; Statistics Canada, "Population Estimates on July 1, by Age and Gender." RNAO calculation.
[62] Statistics Canada, "Gross Domestic Product, Income-Based, Provincial and Territorial, Annual."
[63] Rosella et al., *Projected Patterns of Illness in Ontario*.

Figure 19: Projected patterns of multimorbidity[64]



One recent report forecasts that the incidence of major illness in the population aged 65 and older will continue to increase – from 41 per cent in 2002 to 53 per cent by 2040.[65] This is due in part to underlying trends in chronic disease risk in Canada: "The number of people living with major illnesses has nearly doubled in the past 20 years, from approximately 960,000 in 2002 to 1.8 million in 2020. We expect this trend to continue, reaching a high of 3.1 million people living with major illness by 2040. An additional 5.1 million people will be living with some illness in 2040, up from 2.9 million in 2002 and 3.9 million in 2020."[66]

The chronic disease trend set out in the report calls for a population health approach to health systems. As Rosella and colleagues note: "The current trajectory of population health in Ontario is the expansion of morbidity, the idea that more and earlier time will be spent in poor health. The alternative, compression of morbidity, requires that onset of chronic disease is delayed into later life. To achieve compression of morbidity, illness must be prevented and postponed at a population scale. This means people spend the fewest years possible in poor health."[67]

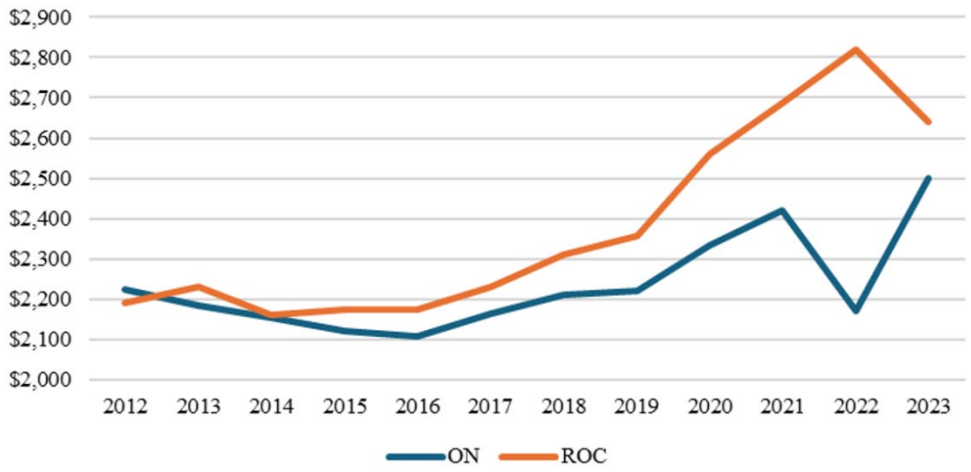
In part, this means stronger partnerships between public health and all sectors of the system, particularly primary care for early detection and management of chronic conditions. More than that, it means looking further upstream to address social and structural determinants of health. Rosella and colleagues note that "trends in population health and healthcare needs result from a complex interplay between demographic transitions, disease trends, and underlying determinants of health. For projections to be useful for health system

[64] Rosella et al.
[65] Rosella et al.
[66] Rosella et al.
[67] Rosella et al.

planning, disease prevention and management, each of these dimensions needs careful consideration."[68]

To date, Ontario not only lags the rest of Canada with respect to health-care expenditures; its fiscal effort addressing determinants of health is also weak. The province's per capita spending on social and youth services, poverty programs and housing support has been consistently below the rest of Canada since 2013. At present, just to reach the Canadian average, Ontario needs to increase its per capita spending on social protection by at least 5.6 per cent.

Figure 20: Consolidated provincial-territorial and local governments social protection spending per capita (constant 2023$)[69]

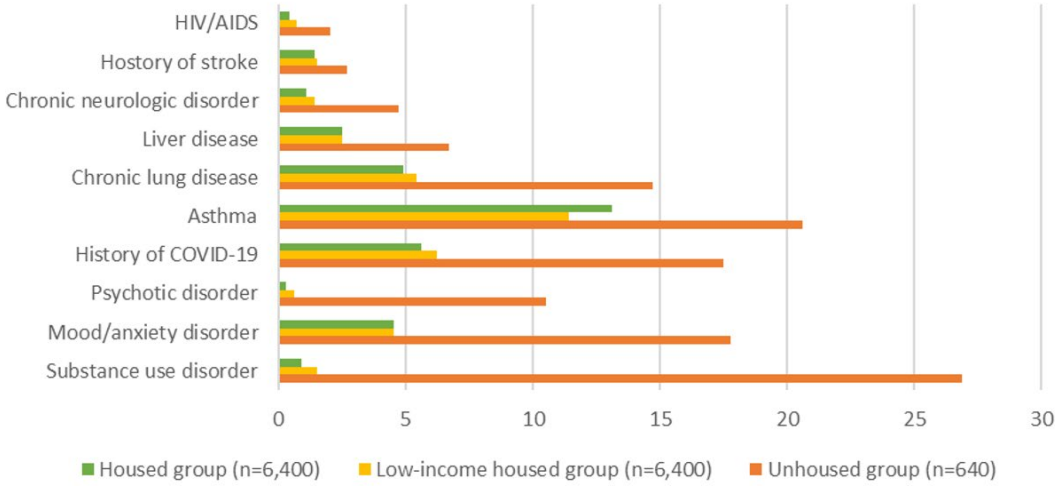


While Rosella and colleagues leave the task of accounting for health risks of different population subgroups for future study, they make it clear that an equity lens is necessary because of the obvious intersection of the determinants of health. Housing status, for example, sits at the intersection of several other determinants – including race and ancestral background – and marginalized population sub-groups. In particular, homelessness – the most extreme form of housing insecurity – places people at higher risk for many chronic diseases.

[68] Rosella et al.

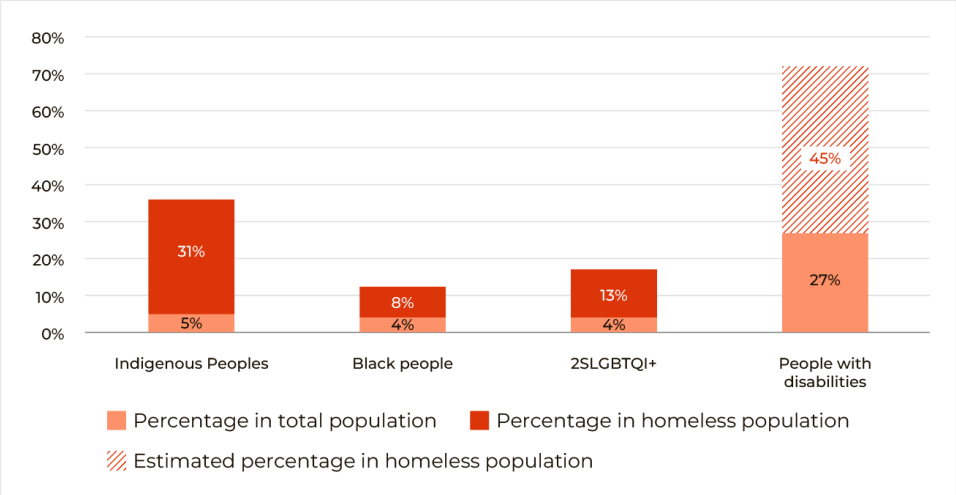
[69] Statistics Canada, "Consumer Price Index, Annual Average, Not Seasonally Adjusted"; Statistics Canada, "Canadian Classification of Functions of Government (CCOFOG) by Consolidated Government. Component," March 30, 2016; Statistics Canada, "Population Estimates on July 1, by Age and Gender"; RNAO calculation.

Figure 21: Chronic disease rates (%) among housed, low-income housed and unhoused group, Toronto, 2021[70]



Several equity-deserving groups – including Indigenous people, Black people, 2SLGBTQI+ communities and people with disabilities – are also at greater risk of homelessness than the general population.

Figure 22: Percentage of four equity-deserving groups in total population vs. unhoused population[71]

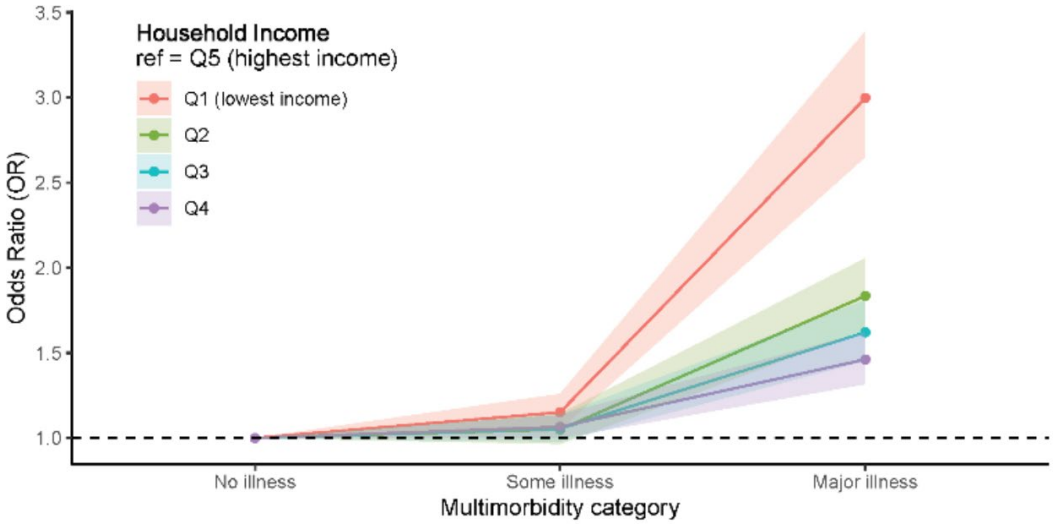


[70] Richard et al., "Disparities in All-Cause Mortality among People Experiencing Homelessness in Toronto, Canada during the COVID-19 Pandemic."

[71] Alzheimer Society of Canada et al., "Meeting Canada's Obligations to Affordable Housing and Supports for People with Disabilities to Live Independently in the Community: Under Articles 19 and 28, Convention on the Rights of Persons with Disabilities And under Articles 2 and 11, International Covenant on Economic, Social and Cultural Rights."

Income security is perhaps the most impactful determinant of health and, like housing status, sits at the intersection of other social determinants of health and health outcomes. It directly impacts individuals' living conditions, psychological wellbeing, and health behaviors such as diet, level of physical activity, or substance use[72] – all of which clearly influence housing status. There is a clear correlation between household income and risk of multimorbidity; the risk of major illness increases as household income decreases, peaking among those in the lowest income brackets.[73]

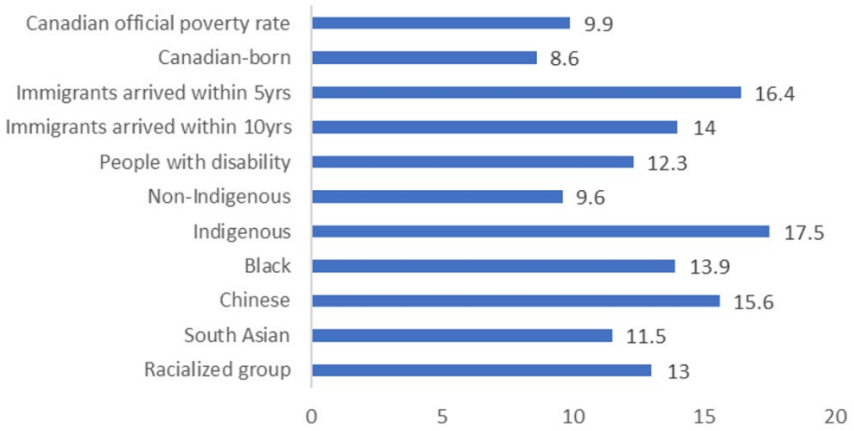
Figure 23: Risk of multimorbidity associated with household income[74]



As with housing status, income insecurity disproportionately affects marginalized populations, including Indigenous people, racialized groups, newcomers and people with disabilities.

[72] Mikkonen and Raphael, *Social Determinants of Health: A Quick Guide for Health Professionals*
[73] Rosella et al., "Projected Patterns of Illness in Ontario."
[74] Rosella et al.

Figure 24: Poverty rates (%) among Canadians, 2022[75]



The need to connect the health system with social programs and services was recognized early on in the HST process. Indeed, the Premier's Council identified in their interim report that the integration of health care delivery meant "considering the impact of the social determinants of health and providing more proactive health care interventions".[76] In their second report, the Premier's Council reported that patients intuitively understood the need to establish close partnerships between, for example, housing, social services and health care.[77] This report called for coordinated support for Ontarians by "strengthening partnerships between health and social services, which are known to impact determinants of health."[78]

Patterns of disease incidence in Ontario make the integration of health care with social programs and services an imperative. The sustainability of the health system depends on addressing the determinants of health to improve outcomes for different sociodemographic subgroups. Without action, the rising incidence of disease will continue to fall disproportionately on marginalized populations, as social and structural risk factors remain unaddressed. The principles of integration and population health that underlie HST and are central to the ECCO model require that:

- The provincial government address structural and social determinants of health with greater fiscal effort.
- Our health system be seamlessly integrated with social services and programs.
- Government and health organizations ground all services and programs in principles of equity, diversity and inclusion.

[75] Statistics Canada, "The Daily — Canadian Income Survey, 2022."
[76] Devlin et al., "Hallway Health Care: A System Under Strain."
[77] Devlin et al., *A Healthy Ontario: Building a Sustainable Health Care System*
[78] Devlin et al.

Equity, diversity and inclusion

The World Health Organization (WHO) defines equity as "the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification".[79] Regarding health, this means everyone has a fair opportunity to attain their full health potential.[80]

Achieving equity in health

In RNAO's view, achieving equity in health means confronting and eliminating the differences that we know are unfair and unjust, and making sure that everyone can be as healthy as possible. It means barrier-free access to care. It also means barrier-free provision of care – that is, it means nurses and nursing students do not face obstacles or suffer stigma, discrimination or racism in their education or practice, and can reach their full potential.

Many factors are involved in health inequity: race, gender, sexual orientation and gender identity, income, education, religion – even our physical environment. RNAO's work to address inequity, informed by our values of human dignity, diversity, inclusivity, fairness and respect, is more than the "right thing to do". It also leads to a more effective and efficient health system because a healthier population requires less care and allows everyone – including nurses harmed by ignorance and stigma – to contribute fully to society.[81]

Access to care, from a holistic, patient-centred perspective, is influenced by the dynamic interaction of system-level and individual factors. At the system level, these factors include the approachability, acceptability, availability, affordability, and appropriateness of services and providers.[82] These factors interact with societal influences, shaping the ability of individuals and populations to recognize health needs, and subsequently seek, reach and engage with affordable health care.[83] Inequitable access refers to unjust modifiable disparities in obtaining necessary health services and the distribution of related barriers.[84]

Research shows that the consequences of such structural inequities as poverty, discrimination, racism, and social exclusion have measurable effects on access to care and

[79] World Health Organization, "Health Equity."
[80] World Health Organization.
[81] RNAO, *Nursing Through Crisis: RNAO's Annual Report 2021-2022*.
[82] Levesque, Harris, and Russell, "Patient-Centred Access to Health Care."
[83] Levesque, Harris, and Russell.
[84] Berg, "Primary Healthcare Policy Research."

health outcomes.[85] Across Ontario and Canada, individuals with lower socioeconomic status, Indigenous peoples, sexual and racial minorities, immigrants, and those with functional limitations consistently exhibit poorer health outcomes and are the least comfortable accessing care services.[86]

International research highlights the inverse care law, where those who are most marginalized have the least access to primary care, despite often having the highest need.[87] Moreover, multiple inequities may overlap and intersect to amplify vulnerability and reduce access[88], including socioeconomic status and poverty[89], social exclusion, discrimination, and racism[90], gender or sexual identity[91], and language, communication, and health literacy.[92]

[85] Haggerty et al., "Does Healthcare Inequity Reflect Variations in Peoples' Abilities to Access Healthcare?"; Mercer and Watt, "The Inverse Care Law"; Public Health Agency of Canada, "Key Health Inequalities in Canada."
[86] Public Health Agency of Canada, "Key Health Inequalities in Canada."
[87] Mercer and Watt, "The Inverse Care Law"; Canadian Institute for Health Information, "International Survey Shows Canada Lags behind Peer Countries in Access to Primary Health Care."
[88] Haggerty et al., "Does Healthcare Inequity Reflect Variations in Peoples' Abilities to Access Healthcare?"
[89] Ahmed et al., "Barriers to Access of Primary Healthcare by Immigrant Populations in Canada"; Ben et al., "Racism and Health Service Utilisation"; Corscadden et al., "Factors Associated with Multiple Barriers to Access to Primary Care"; Khandor et al., "Access to Primary Health Care among Homeless Adults in Toronto, Canada"; Williamson et al., "Low-Income Canadians' Experiences with Health-Related Services."
[90] Ahmed et al., "Barriers to Access of Primary Healthcare by Immigrant Populations in Canada"; Argintaru et al., "A Cross-Sectional Observational Study of Unmet Health Needs among Homeless and Vulnerably Housed Adults in Three Canadian Cities"; Corscadden et al., "Factors Associated with Multiple Barriers to Access to Primary Care"; Gomes et al., "Inequities in Access to Primary Care among Opioid Recipients in Ontario, Canada"; Haggerty et al., "Does Healthcare Inequity Reflect Variations in Peoples' Abilities to Access Healthcare?"; Khandor et al., "Access to Primary Health Care among Homeless Adults in Toronto, Canada"; Kitching et al., "Unmet Health Needs and Discrimination by Healthcare Providers among an Indigenous Population in Toronto, Canada"; Loignon et al., "Perceived Barriers to Healthcare for Persons Living in Poverty in Quebec, Canada"; Mahabir et al., "Experiences of Everyday Racism in Toronto's Health Care System"; Phillips-Beck et al., "Confronting Racism within the Canadian Healthcare System"; Schmidt et al., "A Bridge to Universal Healthcare: The Benefits of Ontario's Program to Make Hospital Care Accessible to All Residents of the Province"; Wen, Hudak, and Hwang, "Homeless People's Perceptions of Welcomeness and Unwelcomeness in Healthcare Encounters."
[91] Comeau, Johnson, and Bouhamdani, "Review of Current 2SLGBTQIA+ Inequities in the Canadian Health Care System"; RNAO, *Promoting 2SLGBTQI+ Health Equity*.
[92] Ahmed et al., "Barriers to Access of Primary Healthcare by Immigrant Populations in Canada"; Argintaru et al., "A Cross-Sectional Observational Study of Unmet Health Needs among Homeless and Vulnerably Housed Adults in Three Canadian Cities"; Bowen, "The Impact of Language Barriers on Patient Safety and Quality of Care"; Edge and Newbold, "Discrimination and the Health of Immigrants and Refugees"; Gilliland et al., "A Geospatial Approach to Understanding Inequalities in Accessibility to Primary Care among Vulnerable Populations"; Khandor et al., "Access to Primary Health Care among Homeless Adults in Toronto, Canada"; Lum, Swartz, and Kwan, "Accessibility and Use of Primary Healthcare for Immigrants Living in the Niagara Region"; Wang and Kwak, "Immigration, Barriers to Healthcare and Transnational Ties."

The current organization of Ontario's health system cannot meet the needs of a population that is aging, growing, and increasing in health and social complexity. To address these challenges, health system transformation should emphasize integrated health services rooted in primary care, multisectoral collaboration to address the broader determinants of health, and the empowerment of individuals and communities – all core to our ECCO 4.0 recommendations. Implementing equity-oriented health care will improve access for marginalized populations, leading to better health outcomes and advancing health equity across the system.[93]

Ontario Health's Equity, Diversity, Inclusion and Anti-Racism framework

RNAO is reassured to see that Ontario Health and the Ministry of Health (Ministry) are highlighting EDI and anti-racism in their guidance instructions to OHTs, as these should be prioritized in all health system transformation activities. We know that equity-deserving populations continue to experience substantial health disparities, including racial and ethnic groups, 2SLGBTQI+ persons, people living with disabilities, individuals with lower socio-economic status, and many others.[94] These health disparities result in higher rates of poor health and disease outcomes across different health conditions.[95] Moreover, Abelson et al. recently found that there has been a striking level of unevenness in how organizations approach the task of engaging with communities, patients, family members, and caregivers in health system transformation efforts.[96] Health inequities can be perpetuated by lack of transparency in decision-making processes, lack of representation of marginalized groups, and resource constraints. [97]

Moreover, threats to further restrict access to care and increase health disparities are real and growing in the form of a political ideology that denies the very existence of racism and gender diversity. Very early in his administration, the recently elected U.S. President issued Executive Order 14151 entitled, "Ending Radical and Wasteful Government DEI Programs and Preferencing"[98] and ushering in, in its terms, "the Constitution's promise of colorblind equality before the law."[99] Executive Order 14151 was quickly followed by Executive Order 14168, "Defending Women From Gender Ideology Extremism and Restoring Biological Truth

[93] Ford-Gilboe et al., "How Equity-Oriented Health Care Affects Health"; Rosella et al., "Projected Patterns of Illness in Ontario."
[94] Bhuiya et al., "Identifying Community-Based Models of Care That Address the Needs of Ethno-Racial Communities."
[95] Bhuiya et al.
[96] Abelson et al., "Building Engagement-Capable Environments for Health System Transformation."
[97] Baxter et al., "Increasing Public Participation and Influence in Local Decision-Making to Address Social Determinants of Health."
[98] National Archives, "Ending Radical and Wasteful Government DEI Programs and Preferencing."
[99] The White House, "President Trump's America First Priorities."

to the Federal Government,"[100] which purports to eliminate the fact and diversity of gender identity by stating that the country now only recognizes two "unchangeable" sexes. This order has echoes in statements made by the leader of Canada's official opposition, the Hon. Pierre Poilievre, who has stated that he was "not aware of any other genders than men and women," raising questions about the kind of policies he would implement were he to become Prime Minister.[101]

EDI and anti-racism: Definitions

Ontario Health's framework provides the following definitions[102]:

Equity: Unlike the notion of equality, equity is not about sameness of treatment. It denotes fairness and justice in process and in results. Equitable outcomes often require differential treatment and resource redistribution to achieve a level playing field among all individuals and communities. This requires recognizing and addressing barriers to opportunities for all to thrive in our society.

Diversity: The range of visible and invisible qualities, experiences and identities that shape who we are, how we think, how we engage with and how we are perceived by the world. These can be along the dimensions of race, ethnicity, gender, gender identity, sexual orientation, socioeconomic status, age, physical or mental abilities, religious or spiritual beliefs, or political ideologies. They can also include differences such as personality, style, capabilities, and thought or perspectives.

Inclusion: Recognizes, welcomes and makes space for diversity. An inclusive organization capitalizes on the diversity of thought, experiences, skills and talents of all our employees.

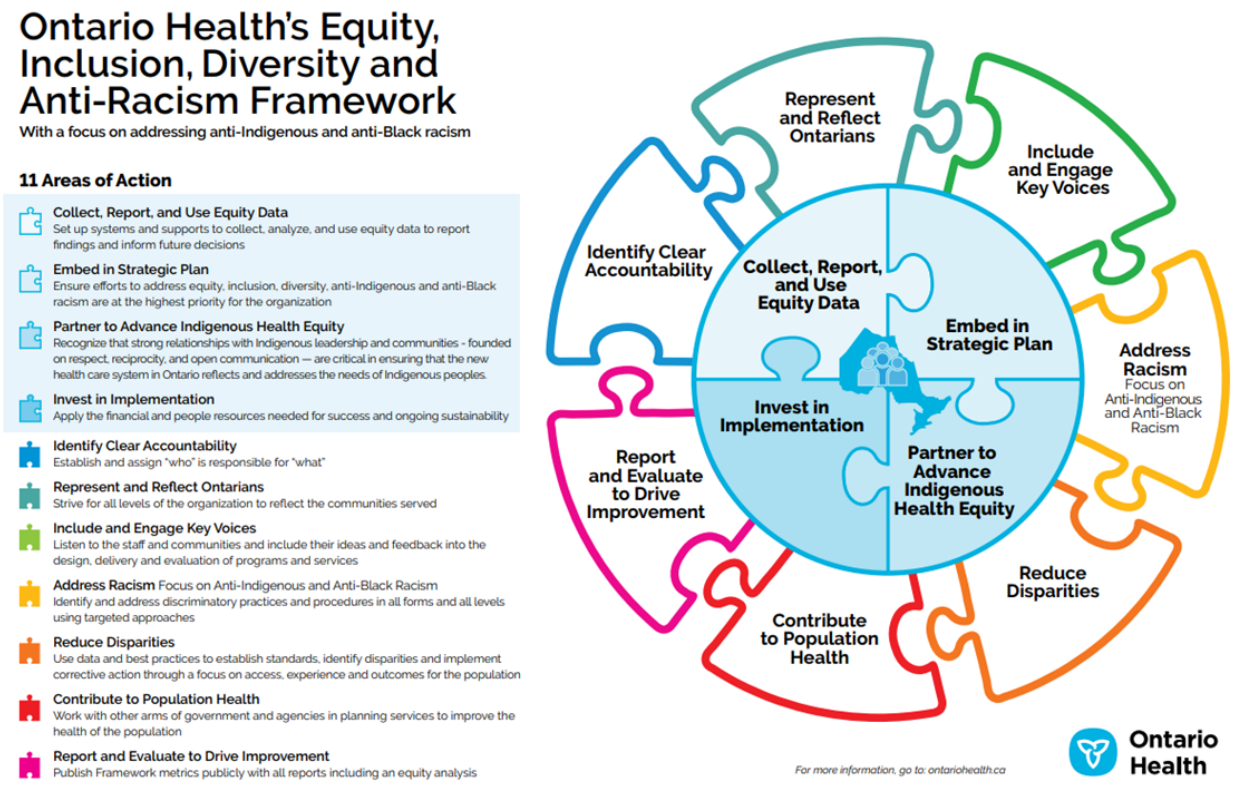
Anti-racism: Both a systematic method of analysis and a proactive course of action. The approach – recognizing the existence of systemic and structural racism – actively seeks to identify, reduce and remove the racially inequitable outcomes and power imbalances between groups and the structures that sustain these inequities.

Ontario Health's Equity, Diversity, Inclusion (EDI) and Anti-Racism framework was created as a tool to guide and promote better health outcomes for patients, families, and providers within Ontario's health system.[103] The framework aims to explicitly identify and address the

[100] Federal Register, "Executive Order: Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government."
[101] Global News, "Miller Says Poilievre Being a 'Jackass' for 'Weaponization' of Gender Identity"; Toronto Star, "Pierre Poilievre Says He Is "Only Aware' of Two Genders."
[102] Ontario Health, *Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework*.
[103] Ontario Health.

impacts of anti-Indigenous and anti-Black racism, providing a foundation for system planning to advance EDI and anti-racism. It is intended for use by health service providers, service provider organizations, and other agencies to inform policies, processes, practices, and supports related to EDI and anti-racism.

Figure 25: Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework[104]



Ontario Health's guidance aims to advance initiatives, engagement, and support for equity-deserving populations by ensuring that equity considerations are embedded across operating plans and activities.[105] OHTs are advised to[106]:

- Leverage existing equity frameworks and population health resources.
- Collaborate with communities to identify barriers to accessing services.
- Develop culturally responsive health supports and communication strategies for diverse populations.
- Identify population-specific supports to improve access to primary care and mental health services.
- Implement community engagement strategies tailored to local needs.

[104] Ontario Health.
[105] Ontario Health, "OHT FY 24/25 Agreement: OHT Operating Plan Guidance."
[106] Ontario Health.

- Enhance access to health services in non-traditional settings.
- Form community partnerships to address the social determinants of health.
- Engage with patients, families, caregivers, First Nations, Inuit, Métis and Urban Indigenous populations, Francophone populations, and other equity deserving communities to build strong relationships, reduce health inequities, and support population health management within OHTs.

In summary, achieving health equity across the system demands a more robust and comprehensive approach to EDI and anti-racism. As highlighted in the *Current state of community care delivery: Key indicators* section (page 21), equity-deserving groups continue to face significant disparities, particularly in accessing primary care in low-income, racially diverse neighborhoods. The disproportionate impact of homelessness and income insecurity on marginalized populations further underscores the urgent need to address the social determinants of health.

While Ontario Health provides a promising roadmap for OHTs, this guidance must be translated into meaningful action. This includes the immediate implementation and rigorous evaluation of EDI and anti-racism strategies across the health system. As health system transformation progresses, EDI and anti-racism must be fully integrated into health-care delivery and embedded as core evaluation criteria for all OHTs. This is a lesson RNAO is committed to upholding.

RNAO's commitment to EDI

RNAO's commitment to EDI and to truth and reconciliation shape the organization and our work. The association has made a sustained and impactful commitment to tackle inequities, end racism and all forms of discrimination in the health care system as well as within the nursing profession.[107]

RNAO recognizes that these injustices remain deeply ingrained in workplace settings, academic institutions, professional associations and other structures affecting health and wellbeing. Evidence shows that health outcomes are impacted by the intersection of gender identity, gender expression and sexual orientation with other determinants of health such as age, income, disabilities, ethnicity and race. We are committed to working with organizations and communities across Ontario and beyond to create change through advocacy, support and education.

[107] RNAO, "Nursing Through Crisis: RNAO's Annual Report 2021-2022"; RNAO, "Black Nurses Task Force Report: Acknowledging, Addressing and Tackling Anti-Black Racism and Discrimination Within the Nursing Profession"; RNAO, *Embracing Cultural Diversity in Health Care: Developing Cultural Competence*; RNAO, *Promoting 2SLGBTQI+ Health Equity*; RNAO, "Nursing Career Pathways".

2SLGBTQI+ and RNAO: Sexually and gender-diverse people and communities have long advocated for their health needs and for acknowledgment of their specific conditions when it comes to their health-care options and outcomes. The physical and mental health inequities which still exist are often experienced differently by 2SLGTBQI+ people.[108]

Since 2007, RNAO's Rainbow Nursing Interest group (RNIG) has supported the 2SLGBTQI+ community. RNIG values evidence-informed, inclusive, reflective, respectful, safe and supportive care and environments for people of all sexual orientations and gender identities and expressions.

Black Nurses Task Force: RNAO launched the Black Nurses Task Force (BNTF) in June 2020, composed of 17 Black nurses and nursing students working in various sectors of the health system with a mandate to tackle systemic racism and discrimination within nursing.

The BNTF's 2022 report, *Acknowledging, Addressing and Tackling Anti-Black Racism and Discrimination Within the Nursing Profession*, included 19 recommendations to tackle structural racism within nursing organizations, regulatory bodies, associations and the broader health system. It is guided by four main pillars: education and awareness building; research; advocacy at all levels; and partnership with allies and stakeholders. The report also includes a scoping review of the literature and results from an online survey of 205 Black nurses across Ontario.[109]

One of the report's key recommendations was to collaborate with the College of Nurses of Ontario (CNO) and other partners to collect race-based data. After persistent advocacy from RNAO, the CNO initiated a "Workforce Census" in February 2024, gathering extensive equity-related data from more than 30,000 nurses. This data collection can be used to inform equitable and inclusive policies, crucial for retaining nurses and ensuring they feel safe and respected.[110]

Black Nurses Leading Change (BNLC) interest group: BNLC, formed in 2023, supports the work of BNTF and continues to inform RNAO and its members on issues affecting Black nurses and nursing students. BNLC advocates for anti-racism, offers mentorship, provides continuing education and a safe space for Black nurses, nursing students and allies to network and interact with each other.

[108] Comeau, Johnson, and Bouhamdani, "Review of Current 2SLGBTQIA+ Inequities in the Canadian Health Care System"; RNAO, *Promoting 2SLGBTQI+ Health Equity*.
[109] RNAO, *Black Nurses Task Force Report: Acknowledging, Addressing and Tackling Anti-Black Racism and Discrimination Within the Nursing Profession*.
[110] College of Nurses of Ontario, "Workforce Census: Demographic and Nursing Practice Report."

RNAO's Indigenous health program: As a professional nursing association, RNAO acknowledges that abusive treatment of Indigenous Peoples by nurses is part of our profession's collective history. For this, we apologize deeply, and we commit to undertaking collective action and reconciliation with Indigenous Peoples.

RNAO's Indigenous Health Program continues to expand partnerships with provincial and national Indigenous groups by developing and creating new BPGs with and for Indigenous communities. RNAO is also growing its BPSO program by working alongside Indigenous health and social service organizations, weaving RNAO's BPGs with local Indigenous traditions and knowledge to support community health and wellness.

RNAO strengthened its commitment to the rights of Indigenous Peoples by introducing the Indigenous Nurses and Allies Interest Group (INAIG) in 2021. Responding to a member's resolution, in 2024 RNAO entered a relationship agreement with the Indigenous Primary Health Care Council, welcoming a Knowledge Keeper to our board of directors. The Knowledge Keeper helps guide the association's work towards truth and reconciliation by advising on priorities related to Indigenous health.

Health Equity Consortium: Formed in 2022, RNAO's Health Equity in Focus Consortium advances EDI across the nursing profession and health system by highlighting the profound experiences of discrimination against nurses and patients and exploring collective responses. Composed of leaders from RNIG, BNTF, BNLC and INAIG, and supported by RNAO's CEO and equity-related program staff, the consortium meets regularly to support RNAO's work and to increase awareness about the effects of systemic racism and discrimination on nurses and patients.

In 2024, the *Canadian Journal of Nursing Research* published the Health Equity Consortium's inaugural article.[111] The article provides insights into advancing health equity within nursing. Future work includes establishing EDI-focused mentorship programs and supporting the development of future equity-related BPGs. Consortium members have also published articles in peer-reviewed journals on tackling discrimination and advancing equity in the nursing profession.[112]

[111] Gauthier et al., "Health Equity Consortium."
[112] Cooper Brathwaite et al., "Tackling Discrimination and Systemic Racism in Academic and Workplace Settings."; Cooper Brathwaite et al., "Black Nurses in Action"; Cooper Brathwaite, Varsailles, and Haynes, "Building Solidarity with Black Nurses to Dismantle Systemic and Structural Racism in Nursing."

Best practices guided by EDI principles: RNAO continues to expand its BPG expertise into practices that support health and equity. Several existing and forthcoming BPGs focus on cultural safety and EDI – developed with input from people with lived experience– to support nursing curriculums, including:

- Embracing Cultural Diversity in Health Care: Developing Cultural Competence.
- Promoting 2SLGBTQI+ Health Equity.[114]
- Promoting Smoking Reduction and Cessation with Indigenous Peoples of Reproductive Age and Their Communities.[115]
- Work began in October 2023 on a new RNAO BPG focused on anti-Black racism in nursing, set for release in 2026.
- RNAO is planning for additional BPGs related to Indigenous health.

RNAO's Advanced Clinical Practice Fellowship (ACPF) Program: This program supports RNs and NPs in developing clinical expertise. The "equity in nursing and health" stream focuses on advancing EDI within the workplace and aligns with RNAO's commitment to dismantling systemic racism, injustice and discrimination to improve health care for all.

Recommendations

The foundations of the ECCO model

ECCO 3.0 put forward 13 recommendations to bring the ECCO model to life in Ontario.[116] Considering the uneven performance of the health system, the impacts of the COVID-19 pandemic, worsening health determinants, and the ongoing push for system transformation, RNAO re-introduces its model for Enhancing Community Care for Ontarians (ECCO 4.0), this time with 16 recommendations. The following sections present the updated ECCO 4.0 recommendations, but before delving into these, we will first outline the foundational elements of the ECCO model.

[113] RNAO, *Embracing Cultural Diversity in Health Care: Developing Cultural Competence*.
[114] RNAO, *Promoting 2SLGBTQI+ Health Equity*.
[115] RNAO, *Promoting Smoking Reduction and Cessation with Indigenous Peoples of Reproductive Age and Their Communities*.
[116] Of the 13 recommendations in ECCO 3.0, nine were "enduring recommendations" that remain essential to achieve ECCO's goals. Another four were "transition recommendations" necessary to move from the current state of the health system to the ECCO model, though their implementation was time- and circumstance-dependent.

The ECCO model

RNAO's ECCO model envisions an integrated system of care with a strong community care sector anchored in primary care. Global evidence shows that high-performing health systems are built on a foundation of robust primary care. Strong primary care sectors are linked to improved patient experiences, reduced morbidity and mortality, greater health equity, and lower overall health-care costs.[117]

Figure 26: The ECCO model of community care

[117] Ontario Primary Care Council, "Position Statement: Care Co-Ordination In Primary Care"; Baker and Axler, "Creating A High Performing Healthcare System for Ontario: Evidence Supporting Strategic Changes in Ontario"; Wodchis et al., "Integrating Care for Older People with Complex Needs"; Starfield, "Family Medicine Should Shape Reform, Not Vice Versa"; Starfield, Shi, and Macinko, "Contribution of Primary Care to Health Systems and Health"; Starfield and Shi, "Policy Relevant Determinants of Health."

What is primary care?

Primary care is the foundation of the health system, providing entry and continuous, person-centred (not disease-oriented) care for most health needs. It delivers services across the care continuum to support the health and wellbeing of all people. Primary care also anchors and shapes the work of all other system levels, playing a central role in coordinating and integrating care throughout the system.[118]

Key attributes of the ECCO model

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

Accessible

As the foundational sector of the health system and embedded throughout communities, primary care should ensure universal access to health care. To fulfill its role as the system's primary entry point, primary care must:

- Extend into a broad spectrum of settings - including non-traditional spaces such as shelters and streets.
- Operate through an interprofessional care model, with NPs and family doctors serving as the most responsible providers (MRP).
- Provide comprehensive, continuous care – covering disease prevention, health promotion, diagnosis, treatment and management of health needs across the lifespan.
- Lead care co-ordination, ensuring all Ontarians can access and navigate services and sectors, especially during care transitions.
- Enable all regulated health professionals – including nurses – to work to their full scope of practice to support timely access to care.

Equitable

A health-care system that improves the health of all Ontarians must decrease avoidable and unfair health gaps between groups – regardless of identity or geographic area. Health equity begins in primary care, as the sector best positioned to ensure that all people – including those marginalized or hard to reach – are connected to the services they need. What is required?

[118] Ontario Primary Care Council, "OPCC Framework for Primary Care"; Starfield, *Primary Care: Balancing Health Needs, Services, and Technology*.

Proactive outreach: Primary care must reach everyone to provide appropriate and timely care. This involves adapting services to the unique needs of marginalized populations, including delivering services in non-traditional settings such as shelters and on the street. It may also involve addressing non-clinical factors that impact health, such as poverty.

Accountability for equity: Primary care must assess and report on the determinants of health affecting the people it serves and be accountable for reducing health inequities. Determinants of health include upstream, non-clinical factors and systemic conditions that shape health and wellbeing.

Collaboration across sectors: Primary care must work in partnership across the health system and with other sectors to improve health outcomes for all – especially those who experience marginalization.[119]

Person-centred

Primary care is the foundation of a person-centred approach, where strong, continuous relationships are built between individuals and their health-care team. Person-centred care requires:

- **Recognition of the whole person:** Moving beyond the bio-medical model, people are valued as more than patients with symptoms or disease requiring diagnosis and treatment.
- **Contextualized care:** Interactions are grounded in each person's unique experience of health over time and understood within the context of their identity, history, experiences, needs, abilities and goals.
- **Shared power and decision-making:** People are respected as experts in their own lives and empowered as partners in care. Decisions and services are guided by what the person wants and needs.[120]

Integrated

An integrated health system must be rooted in primary care to enable continuous, comprehensive and coordinated care. Primary care is best positioned to drive system-wide integration through its role in the community. This requires:

[119] National Collaborating Centre for Determinants of Health, "Let's Talk: Public Health Roles for Improving Health Equity"; Rayner et al., "Delivering Primary Health Care as Envisioned."
[120] RNAO, *Person- and Family-Centred Care*.

- *Interprofessional care and access to the full continuum of services* at the point where people enter the system.
- *Care co-ordination based in the community*, where people live and first access the system, ensuring smooth navigation across services and sectors.
- *Strong connections between primary care teams and the broader health and social system* to support comprehensive care.
- *Provision of evidence-based care* to improve quality and outcomes across the health-care continuum.

Publicly funded

A health system driven by profit cannot adequately serve its population. A publicly funded, primarily not-for-profit, and well-resourced system ensures care is provided to everyone, regardless of their ability to pay. Not-for-profit delivery is consistently linked to better health outcomes and lower costs.[121]

A strong primary care foundation is key to providing quality, cost-effective care. It enables early and appropriate interventions, reducing reliance on costly acute and specialized services.

Investing in accessible, timely, appropriate, equitable, high-quality, comprehensive, and evidence-informed primary care programs reduces pressure on the rest of the system and improves the health of Ontarians.[122]

In ECCO 4.0, we have organized the 16 recommendations into five groups. Those that are foundational to ECCO are divided into three sub-categories, A, B and C: sectoral, cross-sectoral and building nursing careers.

For the nine sectoral and cross-sectoral recommendations, we:

- Bring forward RNAO policy to inform these recommendations.
- Update government progress or action related to these recommendations.
- Identify exemplars in Ontario and other jurisdictions.
- Provide an analysis of the next steps the government must take.

We also provide two recommendations addressing the nursing human resources crisis, three recommendations aimed at better aligning health system transformation with the ECCO model, and two recommendations that address critical determinants of health.

[121] RNAO, "Strengthening Our Publicly Funded, Not-for-Profit Health-Care System."
[122] Ontario Primary Care Council, "OPCC Framework for Primary Care."

A health system that remains precariously underfunded, understaffed, misaligned and fragile, alongside a faltering health system transformation, require that all recommendations flowing from the ECCO model be implemented with haste.

See *Appendix D: ECCO model: Health system transformation progress chart* (page 145) for a summary of RNAO ECCO recommendations since 2012.

A. Sectoral

Recommendation A1: Public health

Improve population health by aligning public health and primary care.

Action items

- Improve system integration and efficiency by fostering collaboration between primary care and public health sectors.
- Support public health to reach its full capacity and potential.
- Recognize and leverage public health expertise and resources to inspire and inform population health planning, management, and accountability.
- Include public health as a mandatory member of all boards of Ontario Health Team (OHT) coordinating corporations.

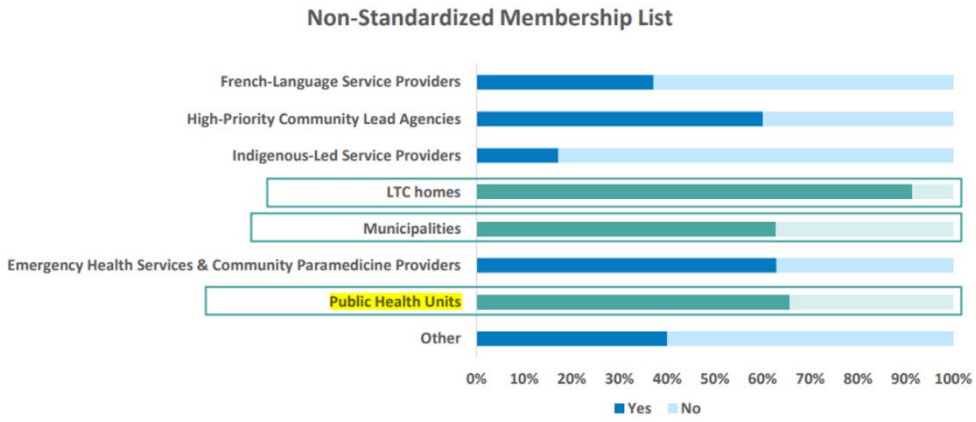
Rationale

A core purpose of health system transformation and a key function of OHTs is population health management[123], a field in which public health holds critical expertise. Excluding public health representation from OHT boards risks preventable gaps and inefficiencies and weakens even high-performing OHTs. While the ministry of health has tasked Primary Care Networks[124] with advancing population health, public health is also essential to fulfilling this role. This is evident in the active engagement of public health personnel in the vast majority of OHTs.[125]

[123] Ontario Health, "Ontario Health's Social Determinants of Health Framework… A Paradigm Shift."
[124] Ontario Ministry of Health, "Primary Care Networks in Ontario Health Teams: Guidance Document."
[125] Cummins, "OHT Update Association of Municipalities of Ontario."

Figure 27: Optional OHT membership – Non-standardized membership list[126]

Teams were asked to complete an optional membership self-assessment to identify which partners are represented in the OHT's collaborative decision-making. Below are the responses from Cohort 1 (n=26 answered) and Cohort 2 OHTs (n=9 answered), ***Total N=35***



Primary care and public health serve distinct but complementary functions. Their goals often overlap, and collaboration between the two has proven effective in enhancing access for marginalized communities, reducing health inequities, improving outcomes, and supporting system integration.[127] These gains result from improved communication, increased system efficiency, and targeted outreach activities.[128] Establishing closer ties between primary care and public health supports whole-system planning, design and delivery.[129] Embedding population health management expertise on OHT boards reflects a true "whole-of-government" approach.

Public health also provides the tools needed to address Ontario's future disease burden. As the "baby boomer" generation ages, rates of multimorbidity and chronic disease are expected to rise sharply, placing immense pressure on the already strained, hospital-centred system.[130] These projections underscore the urgent need for health system transformation and send a clear message: Ontario's current model cannot absorb the growing disease burden. Public health involvement offers a powerful lever for preventing and delaying illness at a population level through disease prevention and health promotion.

At this critical juncture, public health should no longer be siloed. It must be recognized as an integral member of OHT boards to maximize its potential and fully support population-level improvements.

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[126] Cummins.
[127] Valaitis et al., "Addressing Quadruple Aims through Primary Care and Public Health Collaboration."
[128] Valaitis et al.
[129] RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians."
[130] Rosella et al., "Projected Patterns of Illness in Ontario."

Public health can facilitate the process of care integration by bringing:

- **Resources and expertise in preventing and postponing illnesses at the population level.** From a health system perspective, preventing illness and delaying disability are as important as providing acute care.[131] Many chronic diseases, such as hypertension and diabetes, can be prevented through early public health interventions targeting risk factors.[132] Achieving effective and equitable disease prevention requires addressing the social and environmental determinants of health.
- **Expertise on population health management.** Public health brings epidemiological resources and robust expertise in health policy, population data analysis, surveillance and program development. These skills are foundational for addressing health inequities and creating evidence-based strategies for population health management. This enables OHTs to prioritize resources and develop tailored interventions for specific populations.
- **Expertise on intersectoral collaboration.** Public health excels in fostering partnerships across sectors, including health care, education, social services, government and community organizations. This collaborative approach strengthens care integration and promotes a comprehensive response to social determinants of health and EDI, while helping reduce health disparities.

While challenges exist in integrating primary care and public health – such as differences in population focus, accountability, governance, and competing priorities between prevention and treatment[133] – strategies have been proposed to address these issues. Among these[134]:

- Developing clear frameworks to align geographic and attributed population priorities.
- Formalizing collaboration agreements while ensuring public health remains a distinct but integrated entity.
- Establishing shared responsibilities with clearly defined roles in both population-based and individual-level interventions.
- Investing in relationship and partnership building to strengthen collaboration.

[131] Rosella et al.
[132] Rosella et al.
[133] Dion et al., "Examining the Intersections between Ontario Health Teams and Public Health."
[134] Dion et al.; Levesque, Harris and Russell, "Patient-Centred Access to Health Care."

Promising interventions

Health equity data collection: Partners in the Guelph Wellington OHT have implemented the Health Equity Questionnaire – a tool designed to gather information on the social determinants of health. This data helps providers better understand their patients' unique challenges and deliver more personalized care that addresses these factors.[135]

Rx: Community: This social prescribing program was piloted in several of Ontario's community health centres. Interdisciplinary primary care clinicians identified unmet social needs impacting health and referred clients to non-medical resources. A dedicated navigator then helped clients access community resources. Key outcomes included increased client capacity to self-manage their health and decreases in repeat visits by health providers. These benefits help expand primary care capacity, improve access, and address underlying social determinants.[136]

Government promises and progress

The Ontario government has emphasized the need for OHTs to identify target populations and advance improvements in key clinical priorities including chronic disease, mental health and addictions, and palliative care.[137]

To support this, the government introduced a *Social Determinants of Health Framework*[138] and guidance for OHTs to integrate community input in addressing systemic barriers to health (such as access to care), social determinants (such as housing and homelessness), and health disparities.

Some OHTs have begun population segmentation based on needs, risks and barriers – demonstrating progress in identifying target populations. These efforts serve as promising examples of how OHTs are working to prioritize populations, address the determinants of health, and advance population health.

Summary of recommendation

A primary health-care approach encompasses the full spectrum of health services, with a strong focus on equity at both the individual and community level.[139] This includes health promotion and protection, injury and disease prevention, diagnosis, treatment and

[135] Guelph Wellington Ontario Health Team, "Health Equity Questionnaire - Guelph Wellington OHT."
[136] Alliance for Healthier Communities, "Social Prescribing in Ontario: Final Report."
[137] Ontario Health, "OHT FY 24/25 Agreement: OHT Operating Plan Guidance."
[138] Ontario Health, "Ontario Health's Social Determinants of Health Framework… A Paradigm Shift."
[139] McMurray, *Community Health and Wellness*; Rayner et al., "Delivering Primary Health Care as Envisioned."

management across the lifespan – addressing all health needs, including mental health and chronic disease prevention and management.

This people and community-centred approach is not how most primary care is currently delivered in Ontario.[140] Funding must align with this model to ensure comprehensive primary health care is embedded throughout the sector and expanded across the health system.

Public health must therefore be part of all OHTs at both decision-making and service provision levels. Public health brings critical data and insights about the populations they serve, along with expertise in public policy, data surveillance, and programs targeting social determinants of health. Their involvement is essential to understanding and improving the health of local populations.

Finally, a population health approach is crucial at the system-planning level. This approach focuses on improving health and wellbeing across the entire population by addressing determinants of health, engaging communities, and ensuring accountability for equitable health outcomes.[141]

Recommendation A2: Primary care

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

Recommendation A2a: Universal reach of primary care

Ensure that everyone is attached to a family doctor or nurse practitioner (NP) and has 24/7 access to urgent, non-emergency care. Prioritize the provision of primary care through an interprofessional team-based model.

Action items

- Guarantee that every resident has the right to attachment to a primary care provider – either a family doctor or NP – within their neighborhood, like the public school system.
- Guarantee 24/7 access to urgent, non-emergency care in each neighbourhood.
- Implement a strategy to grow the pool of primary care providers, including supporting the training, recruitment, and retention needed to increase the number of primary care providers (NPs and physicians) to meet both the attachment and 24-hour guarantees within five years.

[140] Rayner et al., "Delivering Primary Health Care as Envisioned."
[141] Public Health Agency of Canada, "What Is the Population Health Approach?"; Public Health Agency of Canada, "Population Health"; Public Health Agency of Canada, "Implementing the Population Health Approach."

- Develop a plan with timelines, resources, and mechanisms to conduct a major expansion of primary care services across Ontario to meet both guarantees within five years.
- Expand interprofessional team-based models of primary care by increasing patient enrollment across existing models and creating new team-based primary care clinics.
- Connect all existing primary care providers to interprofessional teams.
- Expand the number of NP-led clinics across Ontario.
- Fund independent NP practice, without user fees, for situations where inclusion into interprofessional teams is not practical nor feasible, such as in small communities.
- Prioritize community-based primary models that have proven effective at increasing access and equity for disadvantaged populations, including nurse practitioner-led clinics (NPLC), community health centres, Indigenous Primary Health Care Organizations and Aboriginal Health Access Centres.

Rationale

Strong primary care systems provide better population health outcomes and improved equity at lower cost.[142] Attachment to primary care is associated with more preventive care, better chronic disease management, lower use of emergency departments and fewer hospitalizations.[143] Yet there are currently more than 2.5 million Ontarians who are "uncertainly attached" to a primary care provider.[144] Moreover, only 25.9 per cent of patients in Ontario had access to team-based care as of 2023.[145]

Neighbourhood-based care: Primary care must be strengthened to ensure comprehensive care is provided at the first point of contact, and to ensure guaranteed access to primary care on a 24/7 basis. Similar to the public school system, Ontarians should be automatically registered or have the right to register at a publicly funded, team-based primary care centre that is within their neighbourhood, and attached to either an NP or a family doctor within that team.[146] The primary care centre acts as a patient's "health-care home" and each would service a defined geographic catchment area to ensure full population coverage.[147]

[142] Starfield, Shi, and Macinko, "Contribution of Primary Care to Health Systems and Health."
[143] Bayoumi et al., "Trends in Attachment to a Primary Care Provider in Ontario, 2008–2018"; Starfield, Shi, and Macinko, "Contribution of Primary Care to Health Systems and Health."
[144] Inspire-PHC, "Primary Care Data Reports."
[145] Inspire-PHC.
[146] Ahmed, "In Conversation with Jane Philpott"; Philpott, *Health for All*; Queen's University, "Dean Jane Philpott to Lead Ontario Primary Health Care Action Team"
[147] Glazier, "Our Role in Making the Canadian Health Care System One of the World's Best"; McCracken and Hedden, "What Can Publicly Funded Schools Teach Us about How to Fix the Family Doctor Shortage?"

As outlined in Dr. Jane Philpott's book, *Health for all: A doctor's prescription for a healthier Canada*[148], the Periwinkle Model is a "primary care home" model inspired by the Quintuple Aim. The model adapts the concept of a patient-centred medical home and is centred on interprofessional primary care teams serving defined populations. Some key elements of the Periwinkle Model[149]:

- The model is designed to serve an entire population of a geographic region.
- Patients are attached to the whole team, and have a regular provider, who might be a family doctor or a nurse practitioner.[150]
- Clinicians (e.g., doctors and NPs) are paid by salary or per shift.
- Accountability is built in to promote quality outcomes.
- Team members and patients welcome learners and volunteers.
- Primary care homes serve as a hub for health and social services.

In Ontario, there is public support for guaranteed access, with a recent survey showing that 70 per cent of respondents agree that primary care providers should be required to accept any resident in the neighbourhood surrounding their office.[151] Neighbourhood-based primary care has the potential to enhance population health when coupled with mapping techniques and a regulatory framework to support distribution of human resources. It could also facilitate re-orientation toward a primary health care approach with collaboration among primary care, community and social services, and public health to improve health equity.[152] Examples of systems organized in this manner can be seen in Finland, Norway, and Spain.[153]

Improving access: Access to primary care on a 24/7 basis is another crucial component of primary care expansion. Today, primary care in Ontario is typically available during "standard business hours," five days a week, with some limited availability on Saturdays. Outside those hours, the only recourse for most Ontarians is the local emergency department. This is not rational from a system standpoint and contributes to overcrowded emergency departments. Other jurisdictions such as the Netherlands offer 24/7 options for urgent primary care, allowing for leaner emergency departments dedicated to actual emergencies.

[148] Philpott, *Health for All*.
[149] Philpott.
[150] Ahmed, "In Conversation with Jane Philpott", "Primary Care Needs OurCare: The Final Report of the Largest Pan-Canadian Conversation about the Future of Primary Care."
[151] Kiran and Macleod, "Primary Care Needs OurCare: The Final Report of the Largest Pan-Canadian Conversation about the Future of Primary Care."
[152] Kiran, "Keeping the Front Door Open."
[153] Shahaed et al., "Primary Care for All."

To achieve guaranteed attachment to primary care on a 24/7 basis, major expansion of primary care services must occur. Moreover, the pool of primary care providers (including NPs, family doctors, RNs, and other health professionals) must be significantly expanded, to ensure adequate health human resources in the primary care sector.[154] The Ontario Medical Association has projected that Ontario currently needs 3,500 family doctors[155]; by 2025 as many as 1.7 million Ontarians will lose their family physician due to retirement alone[156]. These issues are exacerbated by a declining number of medical students entering family medicine and in the number of physicians providing comprehensive primary care, shifting towards narrower scopes of practices and services provided.[157]

What is needed is a cultural shift – we must move away from a physician or NP-centric model and embrace the knowledge and skills of all interdisciplinary team members in a collaborative and shared leadership environment.[158] The strategic integration of NPs within existing models of primary care will help mitigate the impact of the physician shortage[159], and creating a new independent NP model is critical for improving access to care, in particular in smaller, remote and hard-to-serve communities[160]. (See also section C, *Nursing careers in Ontario*, page 103.)

Improving continuity of care: Continuity of care is ultimately improved through consistent interactions with care teams, and through connections between health sectors and services, including social supports. This starts by expanding interprofessional team-based models of primary care, such as NP-led clinics.[161] At present, several different models of care exist in Ontario with differing impacts on equity and access. Ontario's current primary care landscape remains predominantly rooted in physician-focused independent practice models. The availability of team-based care varies across the province due to voluntary implementation and self-selection by physicians, as well as government policies restricting their expansion. Research following previous reform efforts has shown that individuals who were low-income, living in urban areas, new immigrants, and had more complex health and

[154] Dolkar and Grinspun, "Ontario Finally Has an Opportunity to Solve the Primary Care Crisis. Bring in the Nurse Practitioners."
[155] Ontario Medical Association, "Every Ontarian Needs a Family Doctor."
[156] Ontario COVID-19 Science Advisory Table, "Brief on Primary Care Part 2."
[157] Ontario COVID-19 Science Advisory Table; Schultz and Glazier, "Identification of Physicians Providing Comprehensive Primary Care in Ontario."
[158] RNAO, "RNAO Submission to the Ministry of Health on Expansion of Scope of Practice for Nurse Practitioners and Registered Nurses."
[159] Heale et al., "Characteristics of Nurse Practitioner Practice in Family Health Teams in Ontario, Canada"; Kilpatrick et al., "Identifying Indicators Sensitive to Primary Healthcare Nurse Practitioner Practice."
[160] Dolkar and Grinspun, "Ontario Finally Has an Opportunity to Solve the Primary Care Crisis. Bring in the Nurse Practitioners."
[161] RNAO, "Nurse Practitioner Task Force: Vision for Tomorrow."

social needs were more likely to be attached to physicians who remained in independent practice.[162]

Team-based models maximize the roles of NPs, nurses, and other health professionals such as social workers and dieticians to improve timely access to primary care and address the complex health and social needs of patients.[163] They offer more coordinated and better delivery of patient-centred care with better access, reduced wait times, and improved early detection and disease prevention. Team-based models also reduce the need for emergency department visits and hospital readmissions[164], and help decrease the demand on other parts of the system.

Some of the team-based models in use in Ontario include NP-led clinics (NPLCs), community health centres, Indigenous Primary Health Care Organizations and Aboriginal Health Access Centres (AHAC). These models have in common a more egalitarian team structure, with a salaried funding model for physicians and community governance.[165]

Integrating NPs into primary care: NPLCs optimize NP and nursing roles to help improve access to comprehensive primary care, particularly for marginalized and underserved populations.[166] As noted in a very recent scoping study, "NPLCs are well-positioned to support community-based patients living with chronic disease through provision of on-site interprofessional care, continuity in service provision and increased access to primary health-care services."[167] Evidence has shown that NP-led clinics deliver high-quality cost-effective care that is equivalent to and often surpasses physician-led services.[168] Ontario is currently home to 27 publicly funded NPLCs, and this model is expanding into other jurisdictions, such as British Columbia.[169] They embed holistic nursing perspectives in care models, with patients engaged as partners and an emphasis on wellbeing, health promotion, and disease prevention.

Enhancing the integration of NPs into Ontario's primary care sector through NP-led clinics requires:

[162] National Collaborating Centre for Determinants of Health, "Let's Talk: Public Health Roles for Improving Health Equity."
[163] RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians."
[164] Newton, "It Is Time to Invest in Team-Based Care."
[165] Haydt, "Politics and Professions."
[166] Dolkar and Grinspun, "Ontario Finally Has an Opportunity to Solve the Primary Care Crisis. Bring in the Nurse Practitioners."
[167] Floriancic, Garnett, and Donelle, "Chronic Disease Management in a Nurse Practitioner-Led Clinic."
[168] Contandriopoulos et al., "Evaluating the Cost of NP-Led vs. GP-Led Primary Care in British Columbia."
[169] Contandriopoulos et al., "Evaluating the Cost of NP-Led vs. GP-Led Primary Care in British Columbia."

- *Funding for new NPLCs* in areas with high numbers of poorly attached or unattached patients – for example, where people have to travel long distances to access primary care.
- *Increased funding for operational expansion of existing NP-led clinics* to meet community needs and attach new patients to primary care services.
- *Competitive compensation* to recruit and retain NPs and other staff for NPLC operations.

Supporting delivery of care to underserved communities

Many NPs live and practice in rural and remote areas where access to family physicians and other health care providers is poor.[170] A model to fund independent NPs can play a pivotal role by enabling NPs to increase access to primary care in geographically underserved areas by operating independent clinics or joining an existing team.[171]

The independent NP model involves full-time, part-time, casual, or hourly compensation to NPs for their primary care services. Integrating it into Ontario's health system will require competitive compensation, as well as funding for overhead expenses and additional resources. NPs must also be enabled to independently roster patient panels and apply for hospital privileges within their communities to meet patients' needs.

Promising interventions

All Nations Health Partner OHT has developed a blueprint for primary care in collaboration with a 185+ member primary care working group, with the following goals[172]:

- Ground primary care in the Medical Home Model with culturally safe care that respects traditional healing and supports the Quadruple and Quintuple Aims.
- Focus on continuity of care and patient- and family-centred care.
- Ensure provision of comprehensive team-based primary care on and off reserve which addresses Indigenous determinants of health (including education, housing, food security and social supports).

East Toronto Health Partners OHT created a "primary care and community committee" to partnering with multiple organizations from community, hospital, family health team, midwifery, mental health and addiction services. Its focus is to attach patients in the

[170] Canadian Institute for Health Information, "Keeping Pace with Changing Population Needs"; Government of Alberta, "Nurse Practitioner Primary Care Program: Program Guide - Open Government."
[171] Dolkar and Grinspun, "Ontario Finally Has an Opportunity to Solve the Primary Care Crisis. Bring in the Nurse Practitioners."
[172] Corpus Sanchez International, "Primary Care Blueprint for the All Nations Health Partner OHT."

community to solo practitioners or a health team, and help address mental health, homelessness and substance use disorder in the target community.[173]

Frontenac, Lennox & Addington OHT has developed a strategy aiming to attach up to 9,000 people in southeastern Ontario to primary team-based care via three "Health Homes" led by either MDs or NPs.[174]

International examples of guaranteed primary care attachment: Valuable lessons can be drawn from Finland, Norway and Spain to improve primary care access in Ontario. Interprofessional teams are central to primary care delivery in each of these countries, with nurses fulfilling important and expanded roles. Finland and Norway have achieved nearly 100 per cent attachment to primary care.[175] Assignment to a primary care provider is automatic and often at the closest location to where people live, after-hours care is highly organized, and walk-in clinics are generally not publicly funded. Nurses in primary care are often the first point of contact and will provide an initial assessment, triage, and refer to the appropriate level of care.[176]

In Spain, access to primary care is guaranteed by law. Mapping techniques are used in planning to analyze and equitably distribute facilities and personnel, considering rurality, sociodemographics and population health. Regions have regulations to guarantee accessibility, including the defined ratios of providers to residents and geography. Expanded nursing roles, including prescribing, and task sharing within interdisciplinary teams improve capacity. Specialized and continuing education opportunities and harmonized salaries between sectors incentivize practice in primary care. Marti, Peris, and Cerezo[177] point out important insights from Spain to improve access to primary care:

1. Expanding nursing roles and task sharing within interdisciplinary teams helps improve capacity.
2. Team-based care results in better coordination and integration of health and social services.
3. Policymakers must consider barriers to teamwork, including administrative and regulatory barriers, reduced autonomy, and precarious working conditions.

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[173] East Toronto Health Partners Ontario Health Team, "In Development Ontario Health Teams Progress Report."
[174] The Frontenac, Lennox & Addington Ontario Health Team, "Increasing Access to Primary Care Close to Home."
[175] Dedeu et al., "Building Primary Care in a Changing Europe: Case Studies [Internet]. Spain"; Shahaed et al., "Primary Care for All."
[176] Dedeu et al.
[177] Martí, Peris, and Cerezo, "Accelerating Multidisciplinary Teamwork to Address Emerging Primary Care Needs in Three Spanish Regions."

4. Regulations enabling nurses to work to their full scope (e.g., prescribing) are essential for effective team-based care.
5. Specialization and continuing education opportunities can incentivize practice in primary care.

International example of 24/7 primary care: The Netherlands

- General practitioners (GPs) serve as the first line of contact for care that is not immediately life threatening and are responsible for 24/7 care of their patients.[178]
- GPs work together in cooperatives to provide after-hours care (overnight and on weekends) to patients in a larger region. All patients must call before being seen. If a GP deems that emergency care is needed, they send an electronic note and provide a warm hand-off by calling the emergency department physician.[179]
- Patients cannot go to the ER without a referral from their GP, which is facilitated by timely availability of GP offices by phone and in person. GP offices also have a specific phone line for emergencies.[180]
- For life-threatening emergencies, patients would call an ambulance, but in all other situations, patients must call their GP offices, where they are evaluated and triaged using triage algorithms.[181]

Government promises and progress

Nurse practitioner-led clinics (NPLCs): Funding was announced for two new NPLCs (Ottawa and Owen Sound) and one expanded NPLC (Innisfil) in 2024. That year, the government also funded a service expansion across four primary care teams for Glengarry NPLC.

Ontario Budget 2024: On Feb. 1, 2024, Ontario announced an investment of $110 million in 2024–25, to connect up to 328,000 people to a primary care provider. In Ontario's 2024 budget, the government pledged a total investment of $546 million over three years, starting in 2024–25, aiming to connect 600,000 people to team-based primary care through new and expanded interprofessional care teams. In January 2025, the Ontario government announced $1.4 billion in new funding "to connect two million more people to a publicly funded family doctor or primary care team within four years".

Dr. Jane Philpott's Primary Care Action Team: In October 2024, Dr. Jane Philpott was appointed by the Ontario government to lead a new primary care action team with a mandate

[178] Kiran, "How the Dutch Ensure 95% of Citizens Have a Family Doctor."
[179] Kiran.
[180] Kiran.
[181] Kiran.

to connect every person in Ontario to primary health care within the next five years. This plan will also include ensuring more convenient access to existing teams with better service on weekends and after-hours. In January 2025, Ontario's Primary Care Action Plan[182] was released, with the following planned key initiatives:

- Creating and expanding 305 additional teams to attach approximately two million people to primary care.
- Introducing legislation that, if passed, would establish standards outlining what people in Ontario can expect when accessing primary care services.
- Providing regular public updates on progress and performance related to primary care attachment (either to a family doctor or NP), interprofessional teams, access to same day or next day care, and percentage of people who can access their health records virtually.
- Establishing a wait time target of no more than 12 months to be connected with a primary care team.
- Introducing targeted strategies to recruit and retain the workforce needed to support primary care providers and teams, including family doctors, nurse practitioners and other health care professionals.

Summary of recommendation

Despite recent government investments in primary care, more than 2.5 million Ontarians currently lack a consistent source of primary care based on current attachment rates, and this number is expected to rise. It is essential to expand and develop new interprofessional health teams until every Ontarian has access to team-based care, while also renewing efforts to connect all independent physicians with the necessary support. Moreover, effective team collaboration can only be achieved by securing funding for additional health human resources, ensuring fair and competitive compensation, removing existing regulatory and clinical autonomy barriers, and providing interdisciplinary education.

RNAO welcomes the announcement that the provincial government intends to invest $1.8 billion over the next four years to address the crisis in primary care – a focus of RNAO's advocacy for years. We wholeheartedly support Dr. Philpott's vision of an "attachment guarantee" – like that offered by our public school system – where every person living in Ontario will have a most responsible provider within their community. RNAO will continue working with Dr. Philpott and her team to realize a vision of primary care that serves all members of the public.

[182] Ontario Ministry of Health, "Ontario's Primary Care Action Plan Connecting Every Person in Ontario to Primary Care."

Recommendation A2b: Equitable access to primary care

Ensure access to primary care services for everyone, without discrimination or differential treatment. Address barriers to care and the impacts of health determinants through community outreach.

Action items

- Incorporate EDI tools in planning and evaluating services.
- Build relationships between primary care teams and community members, and integrate social interventions to build trust and improve access to services.
- Remove barriers to accessing primary care, and extend primary care services into non-traditional settings, such as shelters, schools, streets and correctional facilities.
- Fund primary care models that are inclusive of upstream social and environmental determinants of health.
- Develop the structures and policies needed to standardize equity-oriented, trauma- and violence-informed health care and system navigation across all communities in Ontario.

Rationale

Existing gaps in primary care are compounded by inequitable access to primary care, which flows from system-level and societal barriers. Evidence shows that many groups experience significant gaps in health-care services in Ontario, including Indigenous Peoples, Francophones, refugees and new Canadians, persons with disabilities, people living on low incomes, 2SLGBTQI+ people, uninsured people, people who are unattached to a primary care provider, and people in supportive care and long-term care.[183] Moreover, the COVID-19 pandemic highlighted and exacerbated existing vulnerabilities and inequalities, calling for targeted interventions and policies to support Black persons, Indigenous persons, 2SLGBTQI+ persons, and persons who live with disabilities.[184]

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[183] Gauvin et al., "Engaging with Patients, Families and Caregivers to Support Ontario Health Teams"; Gauvin et al., "Improving Hospital-to-Home Transitions for Older Adults with Complex Health And Social Needs in Ontario."

[184] Abramovich et al., "A Longitudinal Investigation of the Effects of the COVID-19 Pandemic on 2SLGBTQ+ Youth Experiencing Homelessness"; Comeau, Johnson, and Bouhamdani, "Review of Current 2SLGBTQIA+ Inequities in the Canadian Health Care System"; Islam and Hallstrom, "Health Impacts of the COVID-19 Pandemic among Canadians Living with Disabilities"; Kemei et al., "Impact of the COVID-19 Pandemic on Black Communities in Canada"; Lunsky et al., "COVID-19 Positivity Rates, Hospitalizations and Mortality of Adults with and without Intellectual and Developmental Disabilities in Ontario, Canada"; Mac et al., "The Impact of Comorbidities among Ethnic Minorities on COVID-19 Severity and Mortality in Canada and the USA"; Pickering et al., "Indigenous Peoples and the COVID-19 Pandemic"; Smylie et al., "Uncovering SARS-COV-2 Vaccine Uptake and COVID-19 Impacts among First Nations, Inuit and Métis Peoples Living in Toronto and London, Ontario."

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[185], and racialized groups had higher rates of COVID-19 infection and hospitalization than their non-racialized counterparts during the pandemic.[186]

As the population ages and grows, and inequities widen, patient complexities and burdens throughout the health care system will likely continue to rise.[187] Disparities based on income, marginalization, Indigenous identity, and geography point to inequitable access to primary care.[188] To date, there are severe gaps in access for historically-marginalized communities[189], including Indigenous Peoples[190], 2SLGBTQI+ people[191] and newcomers to Canada.[192]

To close these equity gaps, our primary care system must meet people in the locations they know and trust, and at the hours they are available (including after hours and weekends), through expanded outreach and delivery of services. When coupled with mapping techniques to assess and allocate resources based on population needs, and regulations to define the ratios and distributions of interprofessional health-care workers, neighbourhood-based primary care has the potential to enhance population health and human resource management.[193] Moreover, bringing health-care services to non-traditional settings – for example, parks, libraries, respite centres, food banks, shelters, and mobile vans in parking lots – also increases both access and trust.[194] Co-locating primary care in schools can also increase access to health services for children and youth from vulnerable populations.[195]

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[185] Forchuk et al., "Community Stakeholders' Perceptions of the Impact of the Coronavirus Pandemic on Homelessness in Canada."
[186] McKenzie et al., "Tracking COVID-19 Through Race-Based Data."
[187] Rosella et al., "Projected Patterns of Illness in Ontario."
[188] Inspire-PHC, "Primary Care Data Reports."
[189] McKenzie et al., "Tracking COVID-19 Through Race-Based Data."
[190] National Collaborating Centre for Indigenous Health, "Access to Health Services as a Social Determinant of First Nations, Inuit and Métis Health."
[191] Comeau, Johnson, and Bouhamdani, "Review of Current 2SLGBTQIA+ Inequities in the Canadian Health Care System."
[192] Kiran, "Keeping the Front Door Open"; Inspire-PHC, "Primary Care Data Reports."
[193] Berg, "Primary Healthcare Policy Research"; Glazier, "Our Role in Making the Canadian Health Care System One of the World's Best"; Kiran and Macleod, "Primary Care Needs OurCare: The Final Report of the Largest Pan-Canadian Conversation about the Future of Primary Care"; McCracken and Hedden, "What Can Publicly Funded Schools Teach Us about How to Fix the Family Doctor Shortage?"; Shahaed et al., "Primary Care for All."
[194] Saragosa et al., "Delivering Primary Care in Non-Traditional Healthcare Settings to Individuals Experiencing Homelessness."
[195] Gizaw, Astale, and Kassie, "What Improves Access to Primary Healthcare Services in Rural Communities?"

To increase access to and engagement with care, social interventions and programming must also be leveraged across the health system. Participants in one study prioritized social rather than clinical services for improving neighbourhood health, recognizing the need for stable housing, food, and accessible services before engaging meaningfully with health care.[196]

There are several social interventions that have already been successfully implemented in primary care settings, including social needs screening and data collection, social prescribing, transportation support, and co-location with social programs addressing income security and literacy.[197] Yet, social interventions are not yet a standard part of primary care. Given that access is shaped by the interaction of determinants within and external to the health-care system, integrating social programming can increase the appropriateness of and engagement with primary care. This also reinforces the benefit of interprofessional primary care teams and team-based navigation models that include nurses, social workers, and community outreach workers.[198]

At the system level, structures and policies are needed to standardize equity-oriented, trauma and violence-informed health care and system navigation across all communities in Ontario.[199] Integrating structural competency into education and practice raises awareness of how social, political and economic structures impact patient engagement, which improves care planning.[200]

To inform population health management, 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. Community representation strengthens our capacity to address specific community needs, including[201]:

- 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.[202]

[196] Velonis et al., ""One Program That Could Improve Health in This Neighbourhood Is ____?"
[197] Bloch and Rozmovits, "Implementing Social Interventions in Primary Care."
[198] Alliance for Healthier Communities, "Social Prescribing in Ontario: Final Report."
[199] Ford-Gilboe et al., "How Equity-Oriented Health Care Affects Health."
[200] Metzl and Hansen, "Structural Competency."
[201] RNAO, "Submission Re Proposed New Regulation under the Connecting Care Act, 2019."
[202] RNAO.

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

Promising interventions

The Greater Hamilton Health Network has developed "women's homeless health drop-in days" for low-barrier co-located health and social care.[203]

North Western Toronto OHT has implemented a "community care hub" with flexible hours, no need for a referral, and accessible services co-designed with the community to meet and reflect local needs.[204]

Scarborough Centre for Healthy Communities (Toronto) has launched a mobile health van for people who face challenges accessing traditional health-care services or locations.[205]

The EQUIP intervention, tested at two community health centres in southwestern Ontario, provides education on health equity and population health approaches to help address violence, trauma, discrimination, and racism.[206]

St. Michael's Academic Family Health Team, located in Toronto, has established a multidisciplinary framework of interventions to improve the social determinants of health. Individualized and community-level data is collected to inform organizational changes, shift focus from "downstream" to "upstream" interventions, and advocate for policy change.[207]

Government promises and progress

The Ontario government has recently taken steps to advance equity in primary care through the *OHT Operating Plan Guidance* for the 2024–2025 fiscal year.[208] This guidance directs primary health teams to partner with community groups to co-design and implement integrated programs and services for marginalized populations, including Indigenous, racialized, Francophone and 2SLGBTQI+ communities. Moreover, all OHTs are expected to

[203] Greater Hamilton Health Network, "Women's Health Drop-In Days."
[204] The Health System Performance Network, "Interventions to Address Inequities in OHTs."
[205] Scarborough Centre for Healthier Communities, "Mobile Health Unit."
[206] Lavoie et al., "Sentinels of Inequity."
[207] Pinto and Bloch, "Framework for Building Primary Care Capacity to Address the Social Determinants of Health."
[208] Ontario Health, "OHT FY 24/25 Agreement: OHT Operating Plan Guidance."

leverage the *Ontario Health EDI and Anti-Racism Framework* to improve health equity, with a particular focus on primary care.[209]

As noted, the government has also established a Primary Care Action Team led by Dr. Jane Philpott, tasked with connecting Ontarians to primary care through investments in new and expanded team-based models.[210] These initiatives must be scaled up to ensure equitable access for all Ontarians.

Summary of recommendation

The Ontario government must establish comprehensive evaluation methods for each OHT to ensure the universal delivery of equity-oriented health care. The current guidance offers a strong roadmap, particularly in advancing integrated care through population health management and equity-driven approaches.

This strategy should be fully implemented and evaluated across all OHTs to effectively address persistent health disparities. A shift toward a primary health care model is essential – one that delivers integrated services close to where people live, fosters multisectoral collaboration to address broader social determinants of health, and empowers individuals and communities to improve equity and access to primary care.

Recommendation A3: Home care

Increase access to integrated home and community care services by expanding the publicly funded basket of services. Support and scale home care models within OHTs that promote integration with other sectors.

Action items

- Ensure robust, integrated home and community care services, and transition responsibility to OHTs and home care providers capable of delivering comprehensive care.
- Reform the home-care funding model from a per-visit basis to funding baskets, enabling a person-centred approach that includes a range of nursing interventions and ensures continuity of care and caregiver.
- Assign a primary nurse to each client who works to their full scope of practice and is accountable for total nursing care delivery.
- Award home-care contracts to providers capable of offering a broad range of 24/7 services to prevent fragmented care.

[209] Ontario Health, "Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework."
[210] Ontario Ministry of Health, "Ontario's Primary Care Action Plan Connecting Every Person in Ontario to Primary Care."

- Increase home care funding to support an expanded, publicly-funded basket of home and community services.
- Scale and support models within OHTs that facilitate integration of home care with other sectors.

See *Appendix A: Elements of an integrated home-care* model (page 137) for a breakdown of the key elements of that model.

Rationale

Despite significant population growth, the number of Ontarians receiving home care services has stagnated in recent years. Service hours for nursing and personal support for Ontarians aged 65+ are declining.[211] Demand for home care is projected to grow by 12.1 per cent in 2024–25[212], and the province will need to serve an additional 23,000 home and community care clients annually as the population continues to age.[213] Meeting this demand requires the government to scale up home care funding to align with service needs.

Comprehensive home care services enable frail individuals or those with acute, chronic, palliative or rehabilitative needs to live independently. Ontarians also need reliable support to manage transitions to long-term care facilities when living at home is no longer possible. Timely access to home care allows patients in alternate level of care (ALC) beds to leave hospital sooner, relieving pressure on the acute-care system.

To achieve these outcomes, home and community care must be fully integrated into OHTs and local health service providers. OHT members must collaborate to improve co-ordination across the sector and support scalable models that integrate home care with other health services.[214]

The current funding model – compensating providers per visit – offers limited opportunities for person-centred care and provides few incentives for quality improvement.[215] A new

[211] Financial Accountability Office of Ontario, "Ontario Health Sector"; Kralj and Sweetman, "The Impact of Ontario's Aging Population on the Home Care Sector."
[212] Ontario Community Support Association, "Give Ontarians The Care That's Needed - OCSA Launches Their 2025 Pre-Budget Submission."
[213] Ontario Community Support Association.
[214] "ECCO: Enhancing Community Care for Ontarians – A Three Year Plan (White Paper)"; , "ECCO 2.0: Enhancing Community Care for Ontarians – A Three Year Plan"; , "ECCO Model 3.0: Enhancing Community Care for Ontarians"; , "Submission Re Proposed New Regulation under the Connecting Care Act, 2019"; , "RNAO's Response to Bill 175: Submission to the Standing Committee on the Legislative Assembly"; , "Submission to the Ministry of Health on Bill 135, Convenient Care at Home Act, 2023."
[215] RNAO, "ECCO: Enhancing Community Care for Ontarians – A Three Year Plan (White Paper)"; RNAO, "ECCO 2.0: Enhancing Community Care for Ontarians – A Three Year Plan"; RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians"; RNAO, "Submission to the Ministry of Health on Bill 135,

model is needed, funding baskets of services that support person-centred care and enable a full range of nursing interventions, including:

- health education and teaching,
- treatment and rehabilitation,
- health maintenance,
- social adaptation and integration,
- family caregiver support, and
- end-of-life and palliative care.[216]

Funding should expand access equitably, based on patient and client needs.[217]

Patient experiences are adversely impacted by fragmentation between home and community care and other health sectors. Barriers related to income, language, social circumstances, and complex needs further contribute to inequitable access.[218] These disparities are linked to increased hospitalizations, institutionalization, premature death, and caregiver distress. Expanding, integrating, and ensuring equitable access to home and community care, especially for those facing barriers, is critical.[219]

For these reasons, RNAO's ECCO model calls for home care services that are accessible, equitable, person-centred, integrated and publicly funded. Under health-system reforms, OHTs must award contracts based on quality outcomes and accountability. Contracts should go to providers capable of delivering nursing, personal support and rehabilitation services 24/7, with a single provider responsible for the full service package for each client.[220]

Convenient Care at Home Act, 2023"; SE Health et al., "How to Bring Health Home & Stabilize Ontario's Health Care System."

[216] RNAO, "ECCO: Enhancing Community Care for Ontarians – A Three Year Plan (White Paper)"; RNAO, "ECCO 2.0: Enhancing Community Care for Ontarians – A Three Year Plan"; RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians"; RNAO, "Submission to the Ministry of Health on Bill 135, Convenient Care at Home Act, 2023".

[217] "ECCO Model 3.0: Enhancing Community Care for Ontarians"; , "RNAO's Response to Bill 175: Submission to the Standing Committee on the Legislative Assembly"; , "Submission to the Ministry of Health on Bill 135, Convenient Care at Home Act, 2023"; , "Submission Re Proposed New Regulation under the Connecting Care Act, 2019."

[218] Evans, Waddell, and Lavis, "Examining Intersections Between Ontario Health Teams and Home and Community Care"; Kuluski et al., "Community Care for People with Complex Care Needs"; Laher, "Diversity, Aging, and Intersectionality in Ontario Home Care"; Um and Lightman, "Ensuring Healthy Aging for All: Home Care Access for Diverse Senior Populations in the GTA."

[219] Kuluski et al., "Community Care for People with Complex Care Needs"; Yakerson, "Home Care in Ontario."

[220] RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians," 3; RNAO, "RNAO's Response to Bill 175: Submission to the Standing Committee on the Legislative Assembly," 175; RNAO, "Submission to the Ministry of Health on Bill 135, Convenient Care at Home Act, 2023," 135.

The home care nurse's role must evolve from task-based care to a person-centred model that includes health promotion, continuity of care, and continuity of caregiver. Each client should have a primary nurse working to their full scope of practice, accountable for delivering the complete nursing care required.[221]

Promising interventions

Southlake@home is an innovative, population-based program that interconnects hospital, home and community care, and primary care. Patients are provided with an intensive transitional plan of care from the hospital to their home. Based on a philosophy of activation and enablement, it helps people reach their optimal level of function while ensuring health system sustainability.[222]

The House Calls for Seniors program, led by SPRINT senior care, delivers interdisciplinary care to frail, homebound seniors in their home. Patients receive primary care, chronic and acute disease management, medication administration, interdisciplinary assessments, case management, system navigation, and support with transitions from hospitals and transitional care settings.[223]

SMILE (Seniors Managing Independent Living Easily) allows seniors to remain in their own homes longer by connecting those at risk of losing independence with local services. Clients and their caregivers choose who provides the services and when. Services, coordinated by VON Home and Community Care, are delivered by local agencies, businesses and individuals.[224]

Government promises and progress

- Consolidating the province's 14 regional Home and Community Care Support Services organizations to create a single integrated service organization – Ontario Health atHome.
- Facilitating the assignment of Ontario Health atHome care coordinators to work within OHTs and other frontline care settings to support care transitions.
- Supporting the development, implementation and expansion of innovative models of care with home care and health service providers, such as better hospital-to-home transitions.
- Committing to update the home care procurement and contracting process, to introduce performance standards, update standardized contracts and protect current service volumes.

[221] RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians."
[222] Southlake Health, "Southlake@home."
[223] HouseCalls, "Who We Are."
[224] Victorian Order of Nurses for Canada, "SMILE Program."

- Selecting an initial group of 12 OHTs to incorporate home care starting in 2025, supporting care transitions between primary care, hospital, and home and community care.
- Making the following financial commitments to home and community care:
    - 2021: $548.5 million over three years to expand home care services.
    - 2022: an additional $1 billion over the next three years to further expand home care.
    - 2024: an additional $2 billion over three years in home and community care.

Summary of recommendation

Despite recent government investments in home and community care, much more is needed to keep pace with growing demand. Ensuring equitable access to high-quality, integrated home and community care must remain a central priority for OHTs. This sector is a vital component of a high-functioning, integrated health system – and further optimizing and integrating it will benefit the entire system.

Recommendation A4: Long-term care

Re-imagine long-term care (LTC) as "home" for residents by integrating nursing homes into enhanced community care plans and funding.

Action items

- **Integrate LTC into OHTs:**
    - Ensure that all OHTs integrate LTC facilities as part of their team configuration, enabling seamless connections between LTC homes and the broader health system.
- **Adopt a person-centred care model:**
    - Plan care and services around the individual's unique needs and wishes.
    - Collect sociodemographic data for all LTC residents to better understand and address diverse needs.
    - Increase the number of ethnocultural LTC homes to better serve diverse populations.
    - Equip all LTC homes to deliver care that is equitable and inclusive, respecting the diversity of residents.
- **Enhance quality of care in LTC homes:**
    - *Revise the funding formula* – Adjust the funding formula to reflect the complexity of residents and the quality-of-care outcomes, ensuring that LTC homes that reduce acuity (Case Mix Index, or CMI) through evidence-based care retain the funding to reinvest in staffing and resident programs.
    - *Support continuous quality improvement (CQI)* – Encourage LTC homes to use the RNAO's LTC Best Practices Program to implement CQI initiatives.

- *Mandate key performance indicators (KPIs)* – Require LTC homes to track, measure, and publicly report KPIs, including quality of care, resident and family satisfaction, infection control, and adherence to the Resident Bill of Rights.
- *Reduce LTC waitlists* – Address the LTC waitlist by offering non-profit homes the right of first refusal for development opportunities, along with necessary supports to help them succeed in expansion efforts.

- **Modernize staffing and workforce in LTC Homes:**
  - *Implement the Nursing Home Basic Care Guarantee* – Ensure that every LTC resident receives at least four hours of direct care daily, with a skill mix consisting of 20 per cent registered nurses (RNs), 25 per cent registered practical nurses (RPNs), and 55 per cent personal support workers (PSWs) by 2028.
  - *Increase nurse practitioner (NP) roles in LTC Homes* – Expand funding to increase the number of Attending NPs acting as the most responsible care providers in LTC homes, ensuring all homes have achieved one NP per 120 residents by 2028.
  - *Clinical leadership through NPs or medical doctors* – Fund NPs to take on the role of clinical directors in LTC homes, ensuring quality of life for residents and optimal health outcomes.
  - *Specialized infection prevention and control staffing* – Mandate one RN specializing in infection prevention and control for every 120 residents in LTC homes.
  - *Enhance interprofessional care* – Fund the delivery of one hour of daily care per resident from interprofessional staff, including physiotherapists, rehabilitation therapists, recreational care specialists, speech therapists, social workers, dietitians, and dental professionals.
  - *Ensure safe staffing practices* – Prioritize regulated health professionals in LTC and ban deskilling practices, such as allowing unregulated workers to administer medications.
  - *Expand digital integration of best practices* – Increase funding to digitally integrate BPGs into the care provided to nursing home residents.
  - *Support for directors of care* – Increase compensation and education allowances for directors of care in nursing homes and provide additional resources to support safe, healthy workloads for nurses in these roles.
- **Provide specialized care for persons with dementia:**
  - *Develop dementia-friendly nursing homes* – Create new and renovate existing nursing homes for individuals with dementia, with a focus on smaller congregates (up to seven residents per house) and design based on the preferences of residents.
  - *Establish a Dementia Care Centre of Excellence* – Secure funding to develop and administer a Dementia Care Centre of Excellence to promote the delivery of evidence-based, compassionate care for individuals living with dementia.

Rationale

The COVID-19 pandemic exposed the tragic consequences of decades of underfunding, understaffing, and neglect in Ontario's long-term care (LTC) sector. Successive governments ignored mounting evidence calling for fundamental reforms – better funding, stronger staffing, and a rethinking of how LTC is integrated into the broader health system.[225] This neglect is further evident in the lack of mandatory LTC inclusion in OHT structures and decision-making.[226]

To strengthen community care, LTC homes must play a greater role within OHTs. A McMaster Health Forum[227] synthesis identified ways LTC homes could meaningfully engage with OHTs, including:

- Increasing multidisciplinary collaboration to provide primary care, specialized, and social care services within LTC homes.
- Creating networks with hospitals and specialists to enable smoother referrals and transitions.
- Leveraging digital health tools to support patient care.
- Establishing risk-sharing contracts between LTC and primary care.

Facilitating LTC participation in OHTs can be further supported through incentives for LTC participation in OHTs, clarification of fiscal and clinical accountability structures, and clear expectations and messaging about OHTs.[228]

Despite these opportunities, LTC homes still face profound resource and staffing gaps. As the Auditor General of Ontario noted, "long-term care homes lack the resources and supports to provide their residents with care and a living environment that is centred on their needs".[229] The Auditor General also noted that "recruitment and retention continue to be a significant challenge in the long-term care sector due to a shortage of health human resources in Ontario."[230]

Rising resident acuity – driven by demographic shifts and limited bed capacity – means LTC homes now serve individuals with increasingly complex care needs. The existing skill mix of

[225] RNAO, "Long-Term Care Systemic Failings: Two Decades of Staffing and Funding Recommendations."
[226] DeMaio et al., "Intersections between Ontario Health Teams and Long-Term Care"; Ontario Ministry of Health, "Ontario Health Teams - The Path Forward."
[227] DeMaio et al., "Intersections between Ontario Health Teams and Long-Term Care."
[228] DeMaio et al.
[229] Office of the Auditor General of Ontario, "Long-Term Care Homes: Delivery of Resident-Centred Care."
[230] Office of the Auditor General of Ontario.

nursing and personal care is grossly inadequate, with dangerously low levels of regulated nurses, particularly RNs.[231]

RNAO calls for the urgent implementation of its "Nursing Home Basic Care Guarantee" staffing formula, which sets minimum staffing requirements for RNs, RPNs, PSWs, NPs, infection control practitioners, and other interprofessional staff.[232] This formula would reduce reliance on unregulated providers for inappropriate tasks such as medication administration.[233] Equally important is addressing recruitment and retention of directors of care by increasing resources and supports.

To meet the growing LTC waitlist, RNAO recommends that non-profit homes be given the right of first refusal on development opportunities, along with necessary supports to expand.[234] Additionally, the government must prioritize building smaller, dementia-friendly homes to improve outcomes for residents, staff and the system.[235]

Ontario's LTC residents are diverse – e.g., in ethnicity, culture, language, sexual and gender diversity, religion and spirituality.[236] Yet, the Ontario LTC Commission (2021) found that homes often fail to acknowledge or value this diversity, leading to resident isolation and alienation.[237] These disparities are exacerbated by the absence of standardized sociodemographic data collection.[238] LTC homes must be equipped to serve diverse populations and meet their unique cultural and linguistic needs.[239]

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[231] Office of the Auditor General of Ontario; RNAO, "Nursing Home Basic Care Guarantee: RNAO Submission to the Long-Term Care Staffing Study Advisory Group"; RNAO, "Submission to the Standing Committee on the Legislative Assembly Re Bill 37."

[232] RNAO, "Nursing Home Basic Care Guarantee: RNAO Submission to the Long-Term Care Staffing Study Advisory Group."

[233] RNAO, "RNAO Submission on Fixing Long-Term Care Act Regulations," March 2024; RNAO, "RNAO Submission on Fixing Long-Term Care Act Regulations," October 2024.

[234] RNAO, "Submission to the Standing Committee on the Legislative Assembly Re Bill 37"; RNAO, "RNAO Submission on Fixing Long-Term Care Act Regulations Regarding: Cultural Pilot Project."

[235] RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians"; Sinha et al., "There's No Place Like Home: Why Canada Must Prioritize Small Care Home Models in Its Provision of Long-Term Care." RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians"; Sinha et al., "There's No Place Like Home: Why Canada Must Prioritize Small Care Home Models in Its Provision of Long-Term Care."

[236] Marrocco, Coke and Kitts, "Ontario's Long-Term Care COVID-19 Commission: Final Report"; Office of the Auditor General of Ontario, "Long-Term Care Homes: Delivery of Resident-Centred Care."

[237] Marrocco, Coke, and Kitts, "Ontario's Long-Term Care COVID-19 Commission: Final Report."

[238] Doris Grinspun, "2S-LGBTQ+ Seniors: Our Existence Is Our Resistance!"; Office of the Auditor General of Ontario, "Long-Term Care Homes: Delivery of Resident-Centred Care"; RNAO, "RNAO Submission on Fixing Long-Term Care Act Regulations Regarding: Cultural Pilot Project."

[239] Office of the Auditor General of Ontario, "Long-Term Care Homes: Delivery of Resident-Centred Care."

RNAO has also long warned that the current funding formula creates financial disincentives to improving care.[240] The formula must be amended to reflect current resident acuity and quality outcomes. LTC homes that reduce case mix index (CMI) through evidence-based care should be allowed to reinvest savings into staffing and programs – without facing financial penalties.[241] Relying on retrospective data fails to capture the rapidly changing acuity and complexity of residents.[242]

Continuous quality improvement (CQI) is also possible by leveraging RNAO resources such as the LTC Best Practices Program and the Clinical Pathways digital resource.[243] RNAO has also requested government funding to develop a Dementia Care Centre of Excellence to promote compassionate, evidence-based dementia care.

Given the increasing acuity and complexity of LTC residents, regular review of interventions, medications and referrals is critical. RNAO recommends funding at least one Attending NP in each home.[244] NPs can serve as onsite "most responsible provider" (MRP), managing and coordinating resident care, providing point-of-care staff education, conducting comprehensive assessments, and enabling rapid clinical decision-making – ultimately improving care quality and preventing complications.

Finally, to enhance public transparency and accountability, the government must track, measure and publicly report performance indicators in LTC. Doing so will support continuous quality improvement and ensure all homes meet higher standards of care.[245]

Promising interventions

The **RNAO Long-Term Care Best Practices Program** connects LTC Implementation Coaches with homes across Ontario. These coaches provide free support to help homes

[240] RNAO, "Improving Health for All: RNAO's Challenge to Ontario's Political Parties"; RNAO, "Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System: Closing Submissions of the "; RNAO, "Transforming Long-Term Care to Keep Residents Healthy and Safe"; RNAO, "Submission to the Standing Committee on the Legislative Assembly Re Bill 37"; RNAO, "RNAO's Provincial Election Platform."
[241] RNAO, "Submission to the Standing Committee on the Legislative Assembly Re Bill 37"; RNAO, "Transforming Long-Term Care to Keep Residents Healthy and Safe"; RNAO, "Improving Health for All: RNAO's Challenge to Ontario's Political Parties"; RNAO, "Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System: Closing Submissions of the Registered Nurses' Association of Ontario"; RNAO, "RNAO's Provincial Election Platform."
[242] RNAO, "Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System: Closing Submissions of the Registered Nurses' Association of Ontario"; RNAO, "Submission to the Standing Committee on the Legislative Assembly Re Bill 37."
[243] See *Recommendation B4: Digital health* (page 94).
[244] RNAO, "Nursing Home Basic Care Guarantee: RNAO Submission to the Long-Term Care Staffing Study Advisory Group"; RNAO, "Submission to the Standing Committee on the Legislative Assembly Re Bill 37"; RNAO, "Nurse Practitioner Task Force: Vision for Tomorrow"; RNAO, "RNAO's Provincial Election Platform."
[245] RNAO, "Submission to the Standing Committee on the Legislative Assembly Re Bill 37."

enhance resident care quality and foster a positive work environment for staff through the implementation of RNAO's best practice guideline (BPG) recommendations. Working collaboratively with site management and clinical staff, implementation coaches identify practice gaps and assist with action and sustainability plans to embed evidence-based practices. Launched as a pilot in 2005 and made permanent in 2008, the program has improved outcomes for LTC residents across the province.

Attending NPs in LTC homes help prevent unnecessary hospital transfers, improving residents' quality of life, providing peace of mind for families and staff, and generating cost savings for the health system. They expertly manage chronic conditions, detect and treat medical complications early, coordinate care, improve resident outcomes, and support a holistic, end-of-life care culture.[246] Their presence also fosters a supportive, mentoring environment, enhancing staff capacity to work to their full scope of practice and contributing to staff retention.[247]

The **LTC + Program** is a virtual care program established to help prevent unnecessary hospital transfers. It was developed in partnership with Toronto LTC homes, acute care hospitals, and community services. The program provides LTC homes with access to multiple services through partnerships with regional OHT hub hospitals, including general internal medicine, specialist care, community resources and nurse navigation services.[248]

Campuses of care – as proposed by AdvantAge Ontario – provide a continuum of community-based health and social support services, housing options, and LTC beds conveniently located near one another. They are tailored to reflect local needs and resources within specific geographic locations for older persons with multiple chronic needs. They promote health care integration by facilitating communication, collaboration, and information sharing between providers and community partners.[249]

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[246] Dangwa, Scanlan, and Krishnan, "Integrating Nurse Practitioners Into Long-Term Care"; McGilton et al., "Nurse Practitioners Rising to the Challenge During the Coronavirus Disease 2019 Pandemic in Long-Term Care Homes"; McGilton, Bowers, and Resnick, "The Future Includes Nurse Practitioner Models of Care in the Long-Term Care Sector"; McGilton et al., "Nurse Practitioners Navigating the Consequences of Directives, Policies, and Recommendations Related to the COVID-19 Pandemic in Long-Term Care Homes."

[247] RNAO, "Nursing Home Basic Care Guarantee: RNAO Submission to the Long-Term Care Staffing Study Advisory Group"; RNAO, "Nurse Practitioner Task Force: Vision for Tomorrow"; RNAO, "Submission to the Standing Committee on the Legislative Assembly Re Bill 37"; RNAO, "RNAO Submission on Fixing Long-Term Care Act Regulations," March 2024; RNAO, "RNAO Submission on Fixing Long-Term Care Act Regulations," October 2024; RNAO, "RNAO Submission to the Ministry of Health on Expansion of Scope of Practice for Nurse Practitioners and Registered Nurses"; RNAO, "RNAO's Provincial Election Platform."

[248] Women's College Hospital, "WCH LTC+."

[249] Morton-Chang, Majumder, and Berta, "Seniors' Campus Continuums"; Williams and Morton-Chang, "Campuses of Care: Supporting People, Sustaining Care Systems in Ontario."

Gated communities tailored to people with dementia such as The Village, Canada's first community designed specifically for people with dementia in Langley, B.C., provide more freedom and dignity as an alternative to locked care units. This care concept is modelled on The Hogewyck, a gated "dementia village" in Weesp, Netherlands.[250]

Government promises and progress

The Ontario government has implemented several measures related to LTC in recent years, including:

- Investing up to $4.9 billion over four years to increase LTC staffing, to meet provincial direct care hours for residents by March 31, 2025.
- Legislating requirements for direct hours of nursing and personal care.
- Legislating requirements for direct hours of care provided by other health care professionals.
- Amending regulations to define infection prevention and control (IPAC) lead staffing requirements for LTC homes.
- Providing funding for infection prevention and control personnel, as well as training and education.
- Providing funding to support LTC placements for nursing and PSW students.
- Announcing funding to hire 225 NP positions in Ontario LTC homes.
- Strengthening inspections processes in LTC.
- Introducing funding for clinical decision support tools in LTC such as RNAO Clinical Pathways™.
- Enabling specialized supports to help LTC homes support residents with complex needs, such as Behavioural Supports Ontario, specialized behavioural units and funding through the Local Priorities Fund.
- Utilizing NPs as clinical directors in LTC.

Summary of recommendation

The Ontario government has made several changes to the LTC sector in recent years, but much more is needed. Ontario's Auditor General (2023) recently found that "the Ministry, in conjunction with Ontario Health and long-term care homes, does not have fully effective systems and procedures to ensure that residents receive quality care and services."[251] Further action is required – aligned with RNAO's recommendations – to strengthen staffing,

[250] Vinick, "Dementia-Friendly Design"; "The Village."
[251] Office of the Auditor General of Ontario, "Long-Term Care Homes: Delivery of Resident-Centred Care."

improve quality of care, and ensure equitable, diverse and inclusive care is both delivered and evaluated in Ontario's LTC homes.

B. Cross-sectoral

Recommendation B1: Person-centred care

Establish person-centred approaches to care that prioritize health promotion and disease prevention, and incorporate principles of equity, diversity and inclusion (EDI), and community engagement.

Action items

- Incorporate person-centred care across the health system, focusing on powering people, continuity of care, and shared decision-making.
- Include community representation from the OHT's attributed population on the board of the coordinating corporation.
- Encourage community participation and power communities to actively engage in the planning and decision-making regarding health policies and services.
- Ensure health and social services are tailored to meet the unique needs of the attributed population.

Rationale

Person-centred care is an approach that views people as whole persons and leaders in the care delivery process. It fosters trust and collaboration between patients and providers and enhances outcomes through patient-driven solutions. It starts by planning and delivering services based on where people are at, and builds on this through advocacy, empowerment, respect for autonomy, self-determination and participation in decision-making.

RNAO's *Person-and Family-Centred Care* (2015, 4th edition forthcoming in 2025) BPG recommends: [252]

- Build empowering relationships with the person to promote the person's proactive and meaningful engagement as an active partner in their health care.
- Develop a plan of care in partnership with the person that is meaningful to the person within the context of their life.
- Engage with the person in a participatory model of decision making, respecting the person's right to choose the preferred interventions for their health.

[252] RNAO, *Person- and Family-Centred Care*.

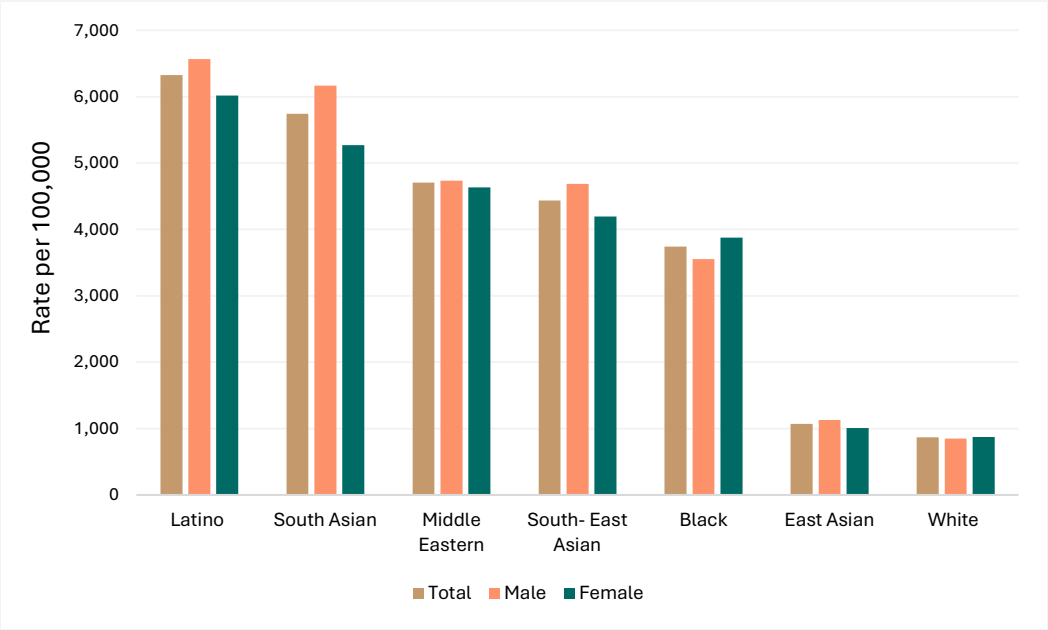
- Personalize the delivery of care and services to ensure care is not driven from the perspective of the health-care provider and organization, by collaborating with the person.
- Create an organizational culture that exemplifies its commitment to person- and family-centred care.
- Design an environment that demonstrably improves the person's experience of health care.
- Collect continuous feedback from the person to determine whether their experience with health care and services was person- and family-centred and utilize this feedback to make improvements at all levels of the health system.
- Government agencies and regulatory bodies monitor, measure, and utilize information from organizations regarding the person's experience of health care to improve health-system performance.

All levels of the health system – starting with primary care – must be bolstered by approaches that integrate equity and community engagement.

Meaningful engagement, including community voices on the boards of OHT coordinating corporations, is essential for effective population health management. This has been a core objective of Ontario's health system transformation from the start. OHTs need information about upstream determinants of health in their communities and must hear directly from people about their lived experiences. This is critical to designing appropriate interventions, allocating resources, and developing responses across both health and social services.[253] The determinants of health, and the complex ways they intersect, have a profound impact on health outcomes.

[253] RNAO, "Submission Re Proposed New Regulation under the Connecting Care Act, 2019."

Figure 28: Cumulative per capita COVID-19 infection rate by race/gender in Ontario (June 26, 2020 to April 21, 2021)[254]



Literature reviews and empirical evidence highlight the positive impact of community participation in health-care decision-making and its connection to improved health outcomes.[255]

- Community participation shifts communities from passive recipients of care to active designers and implementers of health initiatives. This fosters ownership and ensures health resources are used effectively to address local priorities.
- Moving health-care services closer to communities reduces wait times and supports sustainable health improvements for attributed populations.
- Community voices are indispensable to shaping health systems. Meaningful engagement is critical to achieving true health equity and effective population health management.

To embed community perspectives in health system transformation, RNAO recommends mandating a community representative seat on the board of each OHT coordinating corporation. These representatives should focus on three core objectives:

- Identifying inequities in access to health and social services that lead to poor community outcomes.

[254] McKenzie et al., "Tracking COVID-19 Through Race-Based Data."
[255] Laverack, "Improving Health Outcomes through Community Empowerment."

- Providing a voice in policy making, program planning, and service delivery to improve health equity.
- Inspiring broader community engagement in planning and delivering health and social services.

Promising interventions

East Toronto Health Partners (ETHP) OHT partnered with the RNAO Best Practice Spotlight Organizations® (BPSO®) Program in 2019 with a commitment to implement four RNAO BPGs over four years across several partner organizations. ETHP developed its first collaborative Quality Improvement Plan in 2020, using the *Person- and Family-Centred Care* BPG. Partner organizations adopted the shared focus to improve patient and caregiver involvement in care planning and treatment, across various care settings.[256]

ETHP involves patient and caregiver advisors in strategic planning, program design, and service delivery. Based on this approach, ETHP created five additional advisory councils: two resident councils representing specific East Toronto neighbourhoods, two youth advisory councils, and one caregiver advisory group.[257]

Community Advisory Council (CAC): This council was created by ETHP to support all organizations across their OHT. Their CAC started as a group of five patients and caregivers, growing to 60 active members, due to thoughtful recruitment efforts that targeted diverse communities in East Toronto neighbourhoods.[258]

Government promises and progress

Since the launch of the OHT initiative in 2019, the Ontario government has made notable progress in advancing patient partnership within the OHT model. The *Ontario Health Teams Patient, Family and Caregiver Partnership and Engagement Strategy: Guidance Document*[259] established a framework for OHTs to meaningfully involve patients, families, caregivers and communities in delivering person-centred care. The strategy places a strong emphasis on health equity, specifically addressing the unique needs of vulnerable populations, including Indigenous, Black, racialized, and Francophone patients, families or caregivers.[260] The guidance clearly states that, at maturity, all OHTs are expected to engage patients and

[256] Wojtak and Pendevska, "Family and Patient Advisors Bring Real-Life Perspectives to OHT."
[257] Wojtak and Pendevska.
[258] Wojtak and Pendevska.
[259] Ontario Ministry of Health, "Ontario Health Teams - Patient, Family and Caregiver Partnership and Engagement Strategy: Guidance Document."
[260] Ontario Ministry of Health.

communities in person-centred care and advance population health by addressing the determinants of health.[261]

Summary of recommendation

The Ontario government must support OHTs in delivering person-centred care and addressing the broader determinants of health – both essential for promoting health equity and advancing population health management. To better meet community needs and enhance service delivery, it is crucial to include community representation on the boards of OHT coordinating corporations. This representation will provide valuable insights to improve both health and social service delivery.

Recommendation B2: Integrated and coordinated care

Ensure comprehensive and timely care coordination, based in primary care, is available to all Ontarians.

Action items

- Integrate care co-ordination within primary care to improve accessibility and continuity.
- Transition Ontario Health atHome (OHaH) care coordinators to primary care and community-based organizations.
- Expand the care coordinator role to provide comprehensive and consistent services for all Ontarians.
- Develop and publicly release a plan to transfer home care responsibility to designated OHTs, with OHaH providing operational support.
- Place RN care coordinators and navigators in primary care to facilitate system navigation and referrals, while allowing home care to manage assessments, care plans, and services in collaboration with primary care.

See *Appendix B: Functions of care coordinators in primary care* (page 138), for a list of core responsibilities for the care coordinator role.

Rationale

Evidence shows that care coordination is a core function in high-performing primary care models. Primary care-based, RN-led care coordination for complex populations is well supported within the scientific literature.[262] The purposes of the care coordinator role are:

[261] Ontario Ministry of Health; Ontario Health, "OHT FY 24/25 Agreement: OHT Operating Plan Guidance."
[262] The Association of Family Health Teams of Ontario (AFHTO), "Transitioning Care Coordination Resources to Primary Care"; Boult et al., "Early Effects of 'Guided Care' on the Quality of Health Care for Multimorbid Older Persons"; Boyd et al., "Guided Care for Multimorbid Older Adults"; Boyd et al., "The Effects of Guided

- Facilitating access to interprofessional and specialized care for patients.
- Improving system navigation by establishing consistent contacts for patients and families throughout their health system interactions.

Both care coordination and system navigation help leverage long-term relationships and rapport with patients to identify priority needs and barriers.[263] Specific roles include facilitating access to health and social services, promoting continuity of care, and identifying and removing barriers to care and effective health-care utilization.[264]

System navigation models increase accessibility of care and improve timely access to services, especially for patients who face frequent and multiple barriers. Several nurse-led models and team-based models of primary-care system navigation have observed benefits of improved access to care, health outcomes and patient experiences.[265] Clients can engage more meaningfully with primary care when given more equitable opportunities to access health supports.

Expanded care coordination and system navigation approaches are also needed to reach underserved populations. For example, a lack of knowledge about how and where to obtain primary care poses a serious obstacle for people experiencing homelessness.[266] Similarly, recent immigrants may face challenges accessing primary care due to language barriers[267] or low health literacy and knowledge of the local health-care system.[268] Nurse care coordinators and community outreach workers located in primary care can help greatly in increasing approachability and access to coordinated and continuous care. Navigation support from bilingual health or social service providers has also been cited as being critical to success.[269]

Care on the Perceived Quality of Health Care for Multi-Morbid Older Persons"; Leff et al., "Guided Care and the Cost of Complex Healthcare"; Leff and Novak, "It Takes a Team"; Marsteller et al., "Physician Satisfaction with Chronic Care Processes"; Ontario Primary Care Council, "Position Statement: Care Co-Ordination In Primary Care"; Stewart, Schober, and Catton, "Nursing and Primary Health Care: Towards the Realization of Universal Health Coverage."

[263] Dahrouge et al., "The Feasibility of a Primary Care Based Navigation Service to Support Access to Health and Social Resources"; RNAO, "*Primary Solutions for Primary Care*."

[264] Valaitis et al., "Implementation and Maintenance of Patient Navigation Programs Linking Primary Care with Community-Based Health and Social Services."

[265] Carter et al., "Navigation Delivery Models and Roles of Navigators in Primary Care: A Scoping Literature Review."

[266] Argintaru et al., "A Cross-Sectional Observational Study of Unmet Health Needs among Homeless and Vulnerably Housed Adults in Three Canadian Cities"; Khandor et al., "Access to Primary Health Care among Homeless Adults in Toronto, Canada."

[267] Bowen, "The Impact of Language Barriers on Patient Safety and Quality of Care."

[268] Ahmed et al., "Barriers to Access of Primary Healthcare by Immigrant Populations in Canada."

[269] Coller et al., "Complex Care Hospital Use and Postdischarge Coaching"; RNAO, *Transitions in Care and Services*.

Access to enhanced system navigation through care coordinators also helps build confidence in the system. Mistrust of the health-care system is often high, especially in underserved and racialized communities. This may result in a lower use of preventive health services and delays in seeking medical treatment.[270] Helping providers understand the communities and experiences of the people they are supporting helps build needed trust – resulting in better health outcomes. For example, care navigation support has been associated with a reduction in 30-day readmissions[271] and high satisfaction with the support received.[272]

Promising interventions

The Access to Resources in the Community Model is a patient-centred navigation model in primary care to support access to health and social resources. Implemented in four clinics in Ottawa without disrupting existing workflows, the model is highly valued by patients and providers. Navigation improved patients' knowledge of service availability and ability to seek and reach these services.[273]

Primary Care Connections was an intervention piloted in Southwestern Ontario that placed care coordinators within a large family health team. The benefits included improved relationships between providers and patients, improved communication, efficient information sharing, and improved quality. Increased access to information improved providers' ability to effectively address patient concerns.[274]

The **SCOPE (Seamless Care Optimizing the Patient Experience) program** consists of a shared virtual interprofessional care team for primary care providers in Toronto who are not affiliated with teams. SCOPE provides a single access point to several core services, with the Nurse-Navigator service being the most common. On behalf of the primary care professionals registered with the program, the nurse navigators create dozens of connections for patients within their hospitals and in their communities.[275]

[270] RNAO, *Transitions in Care and Services*; Thompson et al., "Community Navigators Reduce Hospital Utilization in Super-Utilizers."
[271] Coller et al., "Complex Care Hospital Use and Postdischarge Coaching"; RNAO, *Transitions in Care and Services*; Xiang et al., "Social Work-Based Transitional Care Intervention for Super Utilizers of Medical Care."
[272] RNAO, *Transitions in Care and Services*; Samuels et al., "'I Wanted to Participate in My Own Care.'"
[273] Dahrouge et al., "The Feasibility of a Primary Care Based Navigation Service to Support Access to Health and Social Resources."
[274] Misra et al., "Prioritizing Coordination of Primary Health Care."
[275] College of Physicians and Surgeons of Ontario, "Building a Network of Support Between Primary Care Physicians and Specialists."

Government promises and progress

The Ontario government has implemented recently several measures related to care coordination:

- Ontario Health atHome was created in 2023 through Bill 135. Its objectives include the provision of operational supports – including care coordination services – to health service providers and OHTs.
- The government's *Ontario Health Teams: Guidance for Health Care Providers and Organizations* [276] set expectations related to care coordination:
- *Year 1 expectations:* Any Year 1 patient should be able to access 24/7 coordination and system navigation services from their OHT.
- *Mature state expectations:* Each OHT is to offer patients 24/7 access to coordination of care and system navigation services and work to ensure patients experience seamless transitions throughout their care journey.

Based on the Ministry's latest 2024 *OHT Operating Plan Guidance*,[277] it appears that the expectation for 24/7 navigation has been removed. Instead, OHTs are now charged with ensuring that "Ontarians know who to contact to find and access the services they need," and ensuring that "health or community services providers within an individual's circle of care are aware of how to navigate patients to available services".[278]

Summary of recommendation

At present, the care coordinator function is largely done through Ontario Health atHome. A promising opportunity to integrate this function into primary care is the assignment of care coordinators to "client-provider organizations" and other frontline health settings, as proposed in the *Convenient Care at Home Act*.[279] Nurses in primary care are ideally situated to act as care coordinators to improve access to timely, integrated, and appropriate primary care for Ontarians given their longitudinal relationship with patients and system-level knowledge.[280]

[276] Ontario Ministry of Health, "Ontario Health Teams: Guidance for Health Care Providers and Organizations."
[277] Ontario Health, "OHT FY 24/25 Agreement: OHT Operating Plan Guidance."
[278] Ontario Health.
[279] RNAO, "Submission to the Ministry of Health on Bill 135, Convenient Care at Home Act, 2023," 135.
[280] RNAO, "Primary Solutions for Primary Care"; RNAO, "ECCO: Enhancing Community Care for Ontarians – A Three Year Plan (White Paper)"; RNAO, "ECCO 2.0: Enhancing Community Care for Ontarians – A Three Year Plan"; RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians."

Recommendation B3: Evidence-based care

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

Action items

- Nurture an evidence-based culture within OHTs.
- Use RNAO BPGs to inform care delivery.
- Enable integrated and person-centred care through the use of RNAO BPGs.
- Encourage OHTs to participate in RNAO's BPSO OHT model.
- Monitor and evaluate the impact of the implementation of evidence-based practice.
- Reinvest all savings from improved outcomes in direct care.
- Fund primary health care-oriented research to support evidence-based decision-making.

Rationale

Consistent with Ontario's health-system transformation and OHT mandates, the ECCO model promotes the use of evidence to guide decision-making and care delivery across the health system. Evidence-based practice is key to advancing a high-quality integrated system of care for all Ontarians and positioning the province as a top performer.[281] It also supports achieving the Quintuple Aim: Improving patient experience, population health, provider experience, cost effectiveness, and health equity (see Figure 29: **The Quintuple Aim** on page 90).

ECCO envisions building a culture of evidence-based practice within OHTs, driven locally with the necessary resources and supports. A major resource is RNAO's Best Practice Guidelines (BPG) Program[282], which includes more than 50 published BPGs designed to improve patient, organizational and health-system outcomes across sectors and settings.

To further support evidence-based practice, RNAO offers the Best Practice Spotlight Organization® (BPSO®) Program[283], an organization-level implementation model. The BPSO Program engages interprofessional staff and persons with lived experience to implement BPGs and sustain evidence-based practice throughout health organizations.

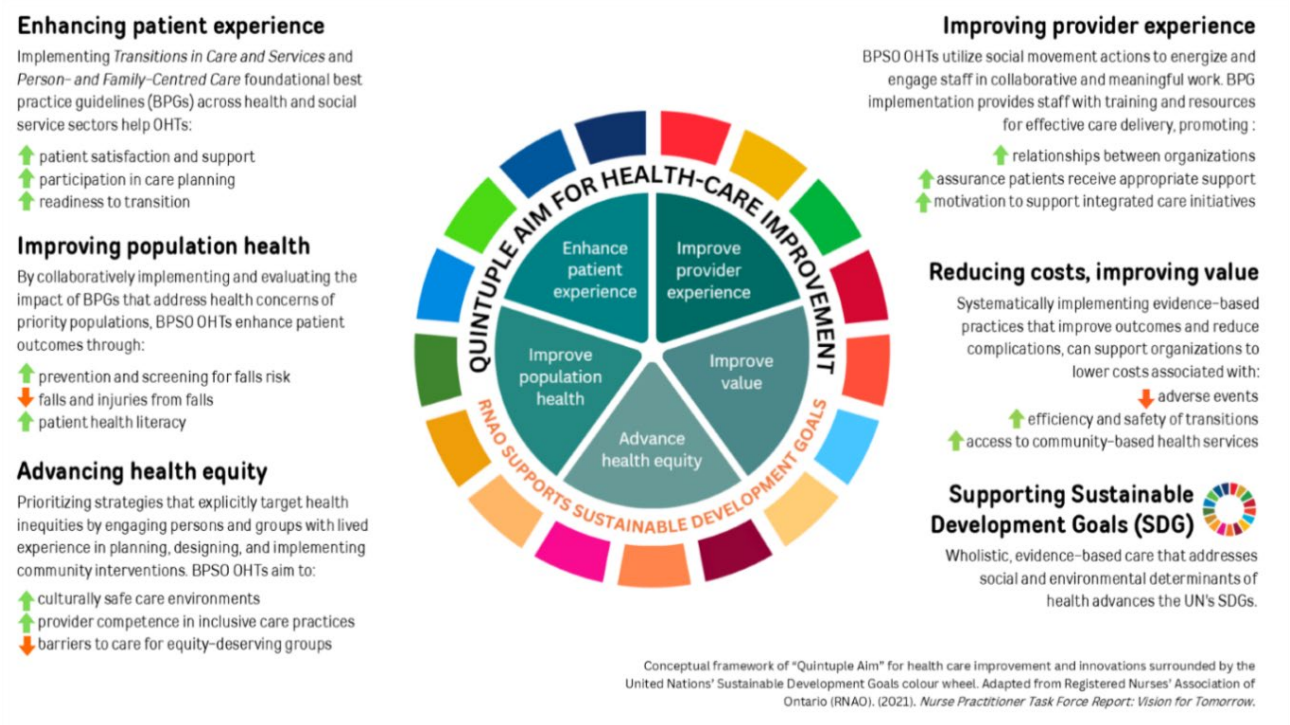
Over the past 25 years, RNAO's BPG and BPSO Programs have grown into a global social movement of science, with more than 1,500 BPSOs implementing RNAO's BPGs worldwide (see RNAO's interactive BPSO map for information)[284]. This strategic approach fosters a

[281] Grinspun and Bajnok, *Transforming Nursing Through Knowledge*.
[282] Registered Nurses' Association of Ontario, "Best Practice Guidelines Program | RNAO.Ca."
[283] Registered Nurses' Association of Ontario, "Best Practice Spotlight Organizations (BPSO) | RNAO.Ca."
[284] RNAO, "Best Practice Spotlight Organizations."

culture of evidence-based care, improves patient experiences and outcomes, reduces cost, and enhances staff satisfaction.

Aligned with the ECCO model, RNAO has developed a new BPSO model responsive to Ontario's health-system transformation and OHTs.[285] In this model, all organizations within an OHT work as one coordinated team to implement BPGs, supported by RNAO coaching. To strengthen integration and person-centred care, BPSO OHTs must implement two mandatory BPGs: *Person- and Family-Centred Care*[286] and *Transitions in Care and Services*[287]. Each OHT also selects two or more clinical BPGs aligned with their priority populations and needs. OHTs participating in RNAO's BPSO OHT model are already demonstrating improved integration, clearer service coordination, and a stronger focus on evidence-based practice across sectors.

Figure 29: The Quintuple Aim[288]



Conceptual framework of "Quintuple Aim" for health care improvement and innovations surrounded by the United Nations' Sustainable Development Goals colour wheel. Adapted from Registered Nurses' Association of Ontario (RNAO). (2021). *Nurse Practitioner Task Force Report: Vision for Tomorrow.*

The ECCO model supports systematic measures to monitor and evaluate the impact of health reforms against the Quintuple Aim. This work is supported through RNAO's Nursing Quality Indicators for Reporting and Evaluation® (NQuIRE®) database, which collects,

[285] RNAO, "North Western Toronto BPSO OHT Implements RNAO's Best Practice Guidelines to Optimize Patient Care."
[286] RNAO, *Person- and Family-Centred Care*.
[287] RNAO, *Transitions in Care and Services*.
[288] RNAO, "Nurse Practitioner Task Force: Vision for Tomorrow."

analyzes and reports comparative data on nursing-sensitive indicators reflecting the structure, process and outcomes of care arising from BPG implementation.[289] Strengthened by a robust international advisory group, NQuIRE helps all BPSOs – including OHTs – advance health-system performance and accountability.[290]

Evidence-based planning and decision-making are critical to fully realizing the ECCO model and anchoring the health system in primary care. Using rigorous data for planning ensures equitable service distribution tailored to community needs. Increased investment in primary-care-oriented research is also essential to identify and address local priorities. Examples include leveraging mapping techniques to allocate resources based on population needs, and developing evidence-based regulations to guide health workforce ratios and distributions.[291]

Promising interventions

RNAO Evidence Boosters[292]: These two-page infographics demonstrate the impact of BPSO's work implementing evidence-based practices, using data from RNAO's NQuIRE® data system. They showcase BPSO success stories on implementation strategies, practice and policy changes, and health outcomes.

Perley Health Community of Care LTC[293]: RNAO's *Risk Assessment and Prevention of Pressure Ulcers (2011)* and *Assessment and Management of Pressure Injuries for the Interprofessional Team (2016)* BPGs were implemented at Perley Health. Clinical outcomes following implementation demonstrated consistent assessment of newly admitted residents for pressure injury risk and a reduction in the percentage of residents whose pressure injury worsened.

Mackenzie Health LTC Home[294]: RNAO's *Person-and Family-Centred Care (2015)* BPG was implemented, resulting in improved resident outcomes. The home consistently involved

[289] Grinspun, "Transforming Nursing through Knowledge: The Conceptual and Programmatic Underpinnings of RNAO's BPG Program."
[290] RNAO, "Nursing Quality Indicators for Reporting and Evaluation®"; RNAO, "International Advisory Council on Evidence-Based Nursing Care Meets at RNAO Head Office"
[291] Berg, "Primary Healthcare Policy Research"; Glazier, "Our Role in Making the Canadian Health Care System One of the World's Best"; Kiran and Macleod, "Primary Care Needs OurCare: The Final Report of the Largest Pan-Canadian Conversation about the Future of Primary Care"; McCracken and Hedden, "What Can Publicly Funded Schools Teach Us about How to Fix the Family Doctor Shortage?"; Shahaed et al., "Primary Care for All."
[292] Registered Nurses' Association of Ontario, "Evidence Boosters | RNAO.Ca."
[293] Registered Nurses' Association of Ontario, "Implementation Impact."
[294] Registered Nurses' Association of Ontario, "Implementation Impact."

residents in developing their personalized care plans, leading to increased satisfaction with their participation. Additionally, the rate of complaints decreased notably.

CBI Home Health[295]: Implementation of RNAO's *Assessment and Management of Foot Ulcers for People with Diabetes (2013)* BPG led to consistent assessment and documentation of bilateral lower extremities in persons with diabetes and foot ulcers. There was also an increase in the percentage of clients prescribed an offloading device.

RNAO leading innovations in care: Improving primary care delivery in Ontario requires a strategic focus on evidence-based solutions, system indicators, and outcomes measurement. RNAO is advancing care delivery through research, system partnerships, and international collaboration by:

- Developing quality indicators for outcomes measurement, including in home care and in long-term care.
- Conducting research on nursing's impact in advancing the Quintuple Aim across settings and sectors.
- Studying the impact of NP-led clinics across jurisdictions in Canada.
- Leading the Best Practice Guidelines (BPG) Program and Best Practice Spotlight Organizations® (BPSO®) program, which support evidence-based practice implementation to improve health outcomes at individual, organizational and systems level.
- Maintaining RNAOs Open Library, providing public access to curated research, articles and reports showcasing the impact of RNAO programs, policy work and advocacy.
- Launching the RNAO Nursing Outcomes Library (May 2025), a curated collection of citations documenting 50 years of nursing outcomes research.

Government promises and progress

The *Ontario Health Teams: Guidance for Health Care Providers and Organizations* document[296] outlines the following expectations for OHTs at maturity:

- OHTs will deliver high-quality care with a focus on quality improvement, using the best available evidence and clinical standards.
- OHT performance will be measured and evaluated against a standard set of indicators to assess the degree of care integration. Provincial and local targets and benchmarks will be established to track progress and support OHT development.

[295] Registered Nurses' Association of Ontario, "Implementation Impact."
[296] Ontario Ministry of Health, "Ontario Health Teams: Guidance for Health Care Providers and Organizations."

- Performance reporting will be introduced over time to provide Ontarians with access to information on health-care improvements and to ensure OHTs are accountable for their funding.

In *The Path Forward* (November 2022), updated OHT requirements include:[297]

- Implementing integrated care pathways to deliver evidence-based care for patients with specific chronic conditions (e.g., congestive heart failure, diabetes, chronic obstructive pulmonary disease, and stroke).
- Anchoring these pathways in primary care and community care, with a focus on prevention and disease management. If hospital care is required, the pathways will support successful transition back to the community, including access to primary care.

According to the 2024–25 *OHT Operating Plan Guidance* document, OHTs are required to:[298]

- Expand the number of patients impacted by OHT-led clinical improvements within and across target populations, applying an equity-based approach.
- Report on the number of patients benefitting from local clinical improvements.
- Report on locally defined OHT performance monitoring indicators.
- Advance clinical improvements for at least two target populations, with plans to expand to additional populations.
- Select clinical priorities from *The Path Forward* based on local needs.
- Align measurement and evaluation of improvements with the Quintuple Aim Framework.

Summary of recommendation

Although Ontario Health has established some requirements for OHTs related to evidence-based care and monitoring, more is needed to ensure evidence-based guidelines are embedded across all care. Current integrated clinical pathways are likely to benefit only select target populations and do not guarantee evidence-based, integrated care for all.

OHTs should be encouraged to engage with RNAO's BPSO OHT model to ensure that evidence-based guidelines are integrated throughout the care trajectory for all attributed populations. Moreover, the adoption of RNAO's BPGs and BPSO model across all health organizations should be promoted to support system-wide evidence-based care. RNAO's NQUIRE database can also be leveraged to monitor and evaluate the structure, process and outcomes of care resulting from integrated clinical pathways and BPG implementation.

[297] Ontario Ministry of Health, "Ontario Health Teams - The Path Forward."
[298] Ontario Health, "OHT FY 24/25 Agreement: OHT Operating Plan Guidance."

Recommendation B4: Digital health

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

Action items

- **Universal access to electronic health records (EHRs):** Mandate EHR access for all Ontarians, ensuring control over one's personal health information.[299] Develop a province-wide strategy based on accessibility, security, comprehensiveness, patient-control, and public funding and administration.
- **Standardized data system:** Establish a shared framework for collecting, analyzing and disseminating population health data to improve decision-making.
- **Enhanced EHR content:** Integrate robust data from primary and community care to establish complete and accessible longitudinal patient records.[300]
- **Seamless care transitions:** Facilitate interconnectivity between primary, specialty, and community care, along with patients and caregivers, to improve integration and safety.[301]
- **Provider engagement in digital adoption:** Involve nurses and health providers in selecting and implementing digital health technologies, following best practices from two RNAO BPGs: *Adopting eHealth Solutions: Implementation Strategies* [302] and *Clinical Practice in a Digital Health Environment*.[303]
- **Privacy and security policies:** Require organizations to implement policies ensuring digital health privacy, security and confidentiality.[304]
- **OHTs and data-driven care:**
    - Require OHTs to collect and report key performance and integration metrics.
    - Ensure data analysis informs resource planning and population health strategies.
- **Digital health implementation by OHTs:**
    - Enable secure patient information sharing.
- **Optimize clinical workflows and care pathways:**
    - Improve patient access to health data.
    - Support population health management, quality improvement and outcome measurement.

[299] RNAO, "Patient-Centred Health Records."
[300] Smith, "Shared Pan-Canadian Interoperability Roadmap."
[301] Smith.
[302] RNAO, *Adopting eHealth Solutions: Implementation Strategies*.
[303] RNAO, *Clinical Practice in a Digital Health Environment*.
[304] RNAO, "RNAO Submission Re Proposed Amendments to Regulations under the Personal Health Information Protection Act."

Rationale

In the realm of digital health technologies, the ECCO model seeks to enhance access and integration across the health system, support person-centred care and increase system efficiency.

Collection and shared use of health data across sectors and settings through digital health technologies informs decisions and ensures accountability, as shown in a recent RNAO BPG, *Clinical Practice in a Digital Work Environment*.[305] Improving access to population health data and personal health information helps supports better integration and collaboration among health providers and persons receiving care.[306]

Interoperability refers to "the secure and timely exchange of health information between systems (e.g., health technology solutions, devices, consumer apps) and the common interpretation of that information devoid of additional action from users."[307] No single longitudinal health record currently exists in Ontario, nor in Canada. Health information is siloed across many different systems, limiting provider access and causing duplication and delayed care, with negative implications on clinical decision-making. This gap creates barriers to care as patient health information spans the entire continuum of care. Lack of interoperability also limits opportunities for patients to access and manage their health information.[308]

Interoperability benefits health providers by consolidating accessible health information in one place, improving decision-making and communication between care teams, and increasing direct care time. Access to personal health records allows people to access and store their own health information, helping patients to become active partners in their care.[309]

When health-care providers and patients have adequate access to health information, the benefits include: decreased re-admission rates; fewer emergency visits; shorter hospital stays; improved transitions of care; increased accuracy and improved timing of diagnosis and treatment; increased quality of care; reduced medication errors; fewer deaths;

[305] RNAO, *Clinical Practice in a Digital Health Environment*.
[306] RNAO, "RNAO Submission Re Proposed Amendments to Regulations under the Personal Health Information Protection Act."
[307] Smith, "Shared Pan-Canadian Interoperability Roadmap."
[308] Smith.
[309] Archer et al., "Personal Health Records"; Nazi et al., "VA OpenNotes"; Curtis et al., "Promoting Adoption, Usability, and Research for Personal Health Records in Canada"; RNAO, "Patient-Centred Health Records"; RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians"; RNAO, "RNAO Submission Re Proposed Amendments to Regulations under the Personal Health Information Protection Act."

decreased burden on patients, families, and caregivers; reduced stress on health-care providers; and improved ability for patients to manage and share health information.[310]

People receive care across different health settings, requiring providers to coordinate care delivery and services. To achieve an integrated health-care system, robust data and information sharing is paramount.[311] Collection and shared use of health data across sectors and settings through digital health technologies aids in informing decisions and ensures accountability.[312] Improved interoperability between care teams allows providers to use patient data across the care continuum, benefiting the providers, patients, and health system as a whole.[313] This benefits the health system by increasing system capacity and improving productivity, leveraging data to optimize planning and evaluation, improving workflows and information sharing, and saving costs.[314]

Digital health technologies support improved access to population health data and personal health information. At the system level, the collection and shared use of population health data ensure accountability and inform decisions about community-specific interventions. RNAO's ECCO model supports a standardized and shared system for collecting data and disseminating population health information across the system.[315] Population health management leverages health and sociodemographic data to identify the unique health and social needs of defined population segments.[316] This data-driven approach allows providers to track health and social needs over time and deliver upstream programs and services to improve population outcomes. To achieve this, data must be thoughtfully collected and utilized for population health management.

Promising interventions

Clinical Pathways[317]: The RNAO Clinical Pathways embed RNAO's BPGs in electronic medical records. They standardize care, measure outcomes consistently, and optimize residents' care experiences and outcomes in all participant LTC homes. RNAO Clinical

[310] Smith, "Shared Pan-Canadian Interoperability Roadmap"; Canada Health Infoway, "2023 Canadian Survey of Nurses: Use of Digital Health Technology in Practice"; Health Canada, "The Government of Canada Introduces the Connected Care for Canadians Act"; RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians"; RNAO, "RNAO Submission Re Proposed Amendments to Regulations under the Personal Health Information Protection Act."
[311] RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians."
[312] RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians"; RNAO, "RNAO Submission Re Proposed Amendments to Regulations under the Personal Health Information Protection Act."
[313] Ontario Health Data Council, "Ontario Health Data Council Report."
[314] Smith, "Shared Pan-Canadian Interoperability Roadmap."
[315] RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians."
[316] Ontario Health Data Council, "Ontario Health Data Council Report."
[317] Registered Nurses' Association of Ontario, "RNAO Clinical Pathways for Long-Term Care Homes | RNAO.Ca."

Pathways are evidence-based, providing key performance indicators for each of the required clinical programs that government can track in real time.[318]

HealthPathways: The Burlington OHT, Greater Hamilton Health Network, and Middlesex London OHT have recently launched the HealthPathways tool in collaboration with Streamliners. HealthPathways provides clinicians with evidence-based resources tailored to the local context, enabling more efficient and productive care, and improving equitable outcomes for patients.[319]

My Chart[320]: MyChart ™ provides resources for patients to actively participate in their care, by providing access to their health information, and facilitating a direct connection with their care team. MyChart ™ is designed specifically for patients, so that they can conveniently access their medical information, appointments, and personal health records from a variety of care settings. Patients are also able to grant shared access to their medical information, so that it can be viewed by their family, caregivers, and health care providers.[321]

Government promises and progress

The Ontario government has undertaken initiatives to improve digital health and interoperability within the province, including a "digital health playbook,"[322] a guidance document regarding the Ontario Health Teams Harmonized Information Management Plan,[323] the Ontario Health Data Council Report,[324] and relevant policies and regulations.

In its most recent OHT operating plan guidance document, the government has also asked OHTs to do the following[325]:

- Integrate a digital, data, and analytics plan focused on supporting clinical priorities within their overall OHT plan.
- Implement the provincial "Patients Before Paperwork Strategy" to relieve administrative burden and eliminate the use of fax technology.

[318] RNAO, "RNAO Submission Re Proposed Amendments to Regulations under the Personal Health Information Protection Act."
[319] Burlington Ontario Health Team, Greater Hamilton Health Network, and Middlesex London Ontario Health Team, "Ontario Health Teams Partner with Streamliners to Bring HealthPathways to Canada: Supporting Integrated Health Outcomes with Groundbreaking New Model."
[320] MyChart, "Login - My Chart."
[321] Sunnybrook Hospital, "MyChart."
[322] Ontario Ministry of Health, "Ontario Health Teams: Digital Health Playbook."
[323] Ontario Ministry of Health, "Ontario Health Teams Harmonized Information Management Plan (HIMP): Guidance Document."
[324] Ontario Health Data Council, "Ontario Health Data Council Report."
[325] Ontario Health, "OHT FY 24/25 Agreement: OHT Operating Plan Guidance."

- Identify digital solutions within the OHT and provide updates about uptake and lessons learned.

Summary of recommendation

The Ontario Ministry of Health has acknowledged major gaps in the provincial electronic health record (EHR) connecting health-care settings, resulting in an inconsistent experience for patients and in barriers for providers who need access to patient data. The immaturity of EHRs undermines person and population health outcomes as well as health system effectiveness. Priority action is required to increase interoperability across health settings and end the health data siloes.

A robust EHR to improve patient outcomes and population health requires that:

- Electronic health information be easily shared.
- Providers have full access to patient EHRs so they make informed clinical decisions.
- Patients access, manage, and consensually share their health information with providers.
- Care coordination be supported by interoperable systems enabling comprehensive and efficient care delivery, especially during care transitions.

The government must conduct ongoing population monitoring to detect, track and prevent threats to public health, requiring robust population-level data.[326] Without integrated health data, government decision-makers and policymakers rely on incomplete information, perpetuating systemic health inequities. Conversely, if all necessary data were available, it could be used to identify, analyze and address inequities.[327]

Recommendation B5: Scope of practice

Optimize the contributions of registered nurses, nurse practitioners and other regulated health professionals by enabling them to work to their full scope of practice.

Action items

- Implement legislative and regulatory changes to fully leverage the scope of practice for RNs and NPs.
- Remove organizational barriers that prevent RNs and NPs from working to their full, legislated scope of practice.
- Provide targeted resources for RNs and NPs in advancing their knowledge, competencies and skills.

[326] Ontario Health Data Council, “Ontario Health Data Council Report.”
[327] Ontario Health Data Council.

- Effectively utilize the clinical nurse specialist (CNS) role across the health system.
- Expand NP authority:
    - Authorize NPs to order additional diagnostic procedures, including contrast-enhanced imaging (CT, MRI) and nuclear imaging such as bone and thyroid scans.[328]
    - Authorize NPs to initiate mental health services, including completing Forms 1 and 2.[329]
- Enhance RN prescribing:
    - Expand the list of approved drugs that RNs can prescribe, aligning with other regulated health professions such as pharmacists and midwives.[330]
    - Extend RN prescribing privileges to hospitals and outpatient settings.
- Authorize RNs to order laboratory and diagnostic testing.[331]
- Integrate RN prescribing education within all BScN programs.[332]

Rationale

A workforce in which nurses and all regulated health professionals practice to their full scope will facilitate timely access to care, meet the comprehensive needs of Ontarians, and enhance system efficiency. With more than 120,000 RNs registered to practice with the College of Nurses of Ontario, nurses represent the largest group of health professionals in the province. RNs are autonomous professionals working across diverse practice settings. Enabling RNs to fully utilize their scope – including expanded roles – will enhance access, care continuity, patient satisfaction, and health outcomes, while optimizing health-care resources.[333]

Policy barriers – particularly around RN prescribing in hospitals – must be addressed. Expanding RN scope, including prescribing in primary care, home care and LTC, would unlock significant potential to serve populations more effectively across sectors.

When effectively utilized, nurses in primary care enhance access by sharing workloads within their scope, allowing physicians and NPs to focus on diagnosis and treatment.[334] However, nurses are often underutilized, performing tasks that could be delegated to

[328] RNAO, “RNAO Submission to the Ministry of Health on Expansion of Scope of Practice for Nurse Practitioners and Registered Nurses.”
[329] RNAO, “Nurse Practitioner Task Force: Vision for Tomorrow”; RNAO, “RNAO Submission to the Ministry of Health on Expansion of Scope of Practice for Nurse Practitioners and Registered Nurses.”
[330] RNAO, “RNAO Submission on RN Prescribing – Proposed Regulation Changes.”
[331] RNAO, "RNAO Submission on RN Prescribing – Proposed Regulation Changes"; RNAO, “ECCO Model 3.0: Enhancing Community Care for Ontarians.”
[332] RNAO, “RNAO Submission on RN Prescribing – Proposed Regulation Changes.”
[333] RNAO, “Mind the Safety Gap in Health System Transformation: Reclaiming the Role of the RN.”
[334] RNAO, “Primary Solutions for Primary Care.”

support staff, such as booking appointments, preparing clinic rooms, or restocking supplies.[335] Full scope utilization is often influenced by organizational policies and practice models – whether independent physician practices or interprofessional teams.

NPs also face persistent barriers preventing them from practicing to their full scope, despite 40 years of evidence demonstrating their positive impact on patient care and system outcomes. [336] Legislative and regulatory barriers, such as restrictions on initiating legal forms for mental health services, further limit NPs' ability to provide comprehensive care.

CNSs must also be effectively utilized within Ontario's health system, to achieve the ECCO model. CNSs are registered nurses (RNs) who have: a master's or doctoral degree in nursing; extensive knowledge and skills in nursing; and significant specialty clinical experience.[337] CNSs make significant contributions to health using a primary health care approach and innovative nursing interventions.[338] Through their role, CNSs improve access to effective, integrated, and coordinated care across the continuum.[339] Their key contributions include[340]:

- Managing the care of complex and/or vulnerable populations through direct care, care coordination, and interdisciplinary collaboration.
- Educating and supporting members of the interdisciplinary team.
- Facilitating change and innovation within the health system.

Unfortunately, due to lack of role clarity, unclear role priorities, and poor tracking of CNS role outcomes, CNS roles are underutilized and poorly implemented in the health system.[341] Yet, CNSs have the potential to improve quality of care and reduce patient mortality when used correctly.[342]

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[335] RNAO.
[336] Canadian Health Services Research Foundation, "Myth"; Carranza, Munoz, and Nash, "Comparing Quality of Care in Medical Specialties between Nurse Practitioners and Physicians"; Health Canada, "Nursing Issues"; Htay and Whitehead, "The Effectiveness of the Role of Advanced Nurse Practitioners Compared to Physician-Led or Usual Care"; Ca and Mg, "Enhancing Health System Integration of Nurse Practitioners in Ontario"; Poghosyan, Boyd, and Clarke, "Optimizing Full Scope of Practice for Nurse Practitioners in Primary Care"; Richards, "Addressing the Crisis in Access to Primary Care"; RNAO, "Increase Access to Care by Fully Utilizing & Appropriately Compensating NPs."
[337] Canadian Nurses Association, "Clinical Nurse Specialist Position Statement."
[338] Canadian Nurses Association; Tracy et al., "Improving the Care and Health of Populations through Optimal Use of Clinical Nurse Specialists"; Kilpatrick et al., "Describing Clinical Nurse Specialist Practice."
[339] Canadian Nurses Association, "Clinical Nurse Specialist Position Statement."
[340] Lewandowski and Adamle, "Substantive Areas of Clinical Nurse Specialist Practice."
[341] Kilpatrick et al., "Describing Clinical Nurse Specialist Practice."
[342] Hashemi et al., "Identifying Structure, Process and Outcome Factors of the Clinical Specialist Nurse."

RNAO has long advocated for maximizing nursing skills, experience and education to improve timely access to quality, evidence-based and person-centred care.[343] Fully utilizing the nursing workforce is a critical strategy to improve health outcomes and advance a high performing health system for all Ontarians.

Promising interventions

Carleton University has begun accepting applications for a new direct entry, full-time compressed three-year (nine-semester) BScN nursing program beginning in September 2025, in collaboration with the Queensway Carleton Hospital. A key and exciting feature of the program – it will be the first in the world to integrate RN prescribing into its curriculum.[344]

The Greater Peterborough Family Health Team introduced a full-scope RN to their team. This increased the range of services they could offer, which improved access to care and reduced its older adult populations' non-urgent emergency department visits by 20 per cent.[345]

Government promises and progress

RNs

- The *Nursing Act (1991)* was amended in December 2023 to expand RN scope of practice in Ontario. The changes allow RNs who complete additional training to prescribe specific medications and communicate related diagnoses.
- As announced in November 2024, RN scope will be expanded to allow them to certify a death when the death is expected.
- The Ontario ministry of health is seeking to integrate RN prescribing education into existing baccalaureate nursing programs to enable prescribing to be a part of entry-level RN competencies. The ministry launched a call for proposals from interested colleges and universities who already have an approved RN prescribing program.

NPs

- NP scope of practice has been expanded as follows:
- Provincial (July 1, 2022) – NPs able to perform point-of-care tests, and order CT/MRI scans under the Healing Arts Radiation Protection Act, 1990, the Regulated Health

[343] , "RNAO Submission on RN Prescribing – Proposed Regulation Changes"; , "Primary Solutions for Primary Care"; "Mind the Safety Gap in Health System Transformation: Reclaiming the Role of the RN"; "Nursing through Crisis: A Comparative Perspective"; "Nursing Career Pathways."
[344] Ontario Ministry of Health, "Ontario Launches First New University Nursing Program in 20 Years"; RNAO, "RNAO Praises Enhancements to Nursing Education in Response to Ontarians' Needs."
[345] Lokanathan et al., "Full Scope RNs in Family Practice Improve Access, Continuity and Reduce ER Visits."

Professions Act, 1991, and the Laboratory and Specimen Collection Centre Licensing Act.

- Federal (Nov. 29, 2023) – NPs authorized to prescribe and possess anabolic steroids other than testosterone under the *Controlled Drugs and Substances Act, 1996*.
- May 3, 2024 – Midwives can access medications through an NP.
- Starting July 1, 2025, nurse practitioners will be able to:
    - Order and apply a defibrillator to provide faster care to someone in cardiac arrest.
    - Order and apply a cardiac pacemaker to make it faster for people to receive care if their heart isn't beating regularly.
    - Order and perform electrocoagulation, a process to treat skin conditions and lesions, such as skin tags, helping people get them removed sooner.
    - Certify a death in more circumstances, improving the end-of-life experience for families after the death of a loved one.
- December 2024 – the government introduced the Support for Seniors and Caregivers Act, 2024.[346] If passed into law, this legislation will allow nurse practitioners to fulfill the medical director role alongside physicians and would rename the position to "clinical director."

Midwives

On May 3, 2024, the list of drugs and treatments that midwives can order and administer were expanded to include:

- Administer routine vaccinations for COVID-19, flu, RSV, tetanus, diphtheria, pertussis, rotavirus, chicken pox.
- Prescribe certain antibacterials, antifungal treatments, antivirals to prevent herpes transmission to newborns, contraceptives and medications to help with lactation and pre- and post-partum side effects.
- Administer treatments for nausea, syphilis and gonorrhea, as well as naloxone to reverse effects of opioids.
- Prescribe and administer additional vitamins, minerals and fluid replacements.
- Administer treatment for the management of labour pain in a hospital setting.

Pharmacists

- Since January 2023, Ontario's pharmacists have been permitted to treat and prescribe for 19 common ailments. As of December 2022, pharmacists were also allowed to prescribe Paxlovid, a COVID-19 medication.

[346] "Bill 235, Support for Seniors and Caregivers Act, 2024 - Legislative Assembly of Ontario."

- In July 2024, a consultation was launched to extend pharmacist prescribing to include treating and prescribing for an additional 14 common ailments, such as sore throat, callus and corns, mild headaches and insomnia, and the ability to order specific diagnostic test and point-of-care tests for prescribing.

Summary of recommendation

Ontario is facing a health human resource crisis, particularly in nursing. To address this, optimizing the education, competencies, skills, and experience of nurses is key. RNAO urges the government to expand the scope of practice for NPs and RNs to improve health system efficiency and effectiveness. Removing barriers to ensure nurses' full participation is essential. Implementing these recommendations will secure timely, high-quality care for Ontarians across all settings, including community care, as well as remote and underserviced communities.

C. Nursing careers in Ontario

Build nursing careers in Ontario by implementing retention and recruitment initiatives, including improved compensation.

Recommendation C1: Nurse retention and recruitment

Enhance nursing retention and recruitment by improving working conditions, strengthening supports across all levels of the profession, and expanding Ontario's nursing workforce and student population.

Action items

- **Improve nurses' working conditions:**
    - Increase nurse staffing across all health-care sectors to ensure safe workloads.
    - Expand full-time roles, reduce reliance on casual workers, and phase out the use of private for-profit nurse staffing agencies by 2027.
    - Prevent deskilling of the nursing workforce, such as replacing regulated with unregulated staff.
- **Improve supports across all levels of the nursing profession:**
    - Increase funding for continuing education, professional development, specialty certifications and leadership training.
    - Strengthen mentorship and retention programs such as the Nursing Graduate Guarantee, Late Career Nurse Initiative, and implement a Return to Nursing Now program for nurses who have left the workforce to re-enter practice.

- Address racism and all other forms of discrimination. Promote equity, diversity, and inclusion (EDI) in all workplaces and in nursing education, professional development, career advancement and mentorship.
- Address workplace violence, staff mental health, staff wellness, and occupational health and safety with robust policies and support.

- **Expand Ontario's nursing workforce and the nursing student population:**
  - Expand access to primary care by increasing the number of seats in NP programs, aiming to reach 7,500 registered NPs in Ontario by 2029 to address the growing number of Ontarians without a regular primary care provider.
  - Expand seats in BScN programs – including four-year and compressed BScN, second-entry, and bridging programs – with the goal of registering 10,000 new Ontario RNs by 2029.
  - Continue to support internationally educated nurses (IEN) residing in Canada while maintaining the BScN as the entry to practice and ban active international recruitment ("poaching").
  - Recruit and retain faculty for nursing programs and promote funding for PhD in Nursing and Doctor of Nursing.
  - Introduce funding to develop paid post-graduate NP residency programs to improve access to specialized care for Ontarians.
  - Integrate retention and recruitment strategies into a comprehensive health human resources interprofessional plan led by the Ministry.

Rationale

Nurses are the largest body of registered health professionals in Ontario and Canada, serving as the backbone of the health system. Their expertise is critical to the system's effective functioning and the health of the public.

Yet, decades of understaffing have compromised the promise and appeal of the nursing profession. Post-pandemic, Ontario's RN understaffing crisis has worsened, impacting nurses' health and wellbeing, as well as patient care. According to 2023–2024 hospital data from the Canadian Institute for Health Information (CIHI), 1 in 17 hospital patients experienced unintentional harm.[347] Between July 2022 and June 2023, staffing shortages caused 203 emergency department closures across 23 Ontario hospitals.[348]

Ontario's nurses are experiencing unprecedented levels of depression, anxiety and stress. Many are leaving permanent jobs for nursing agencies offering better compensation and

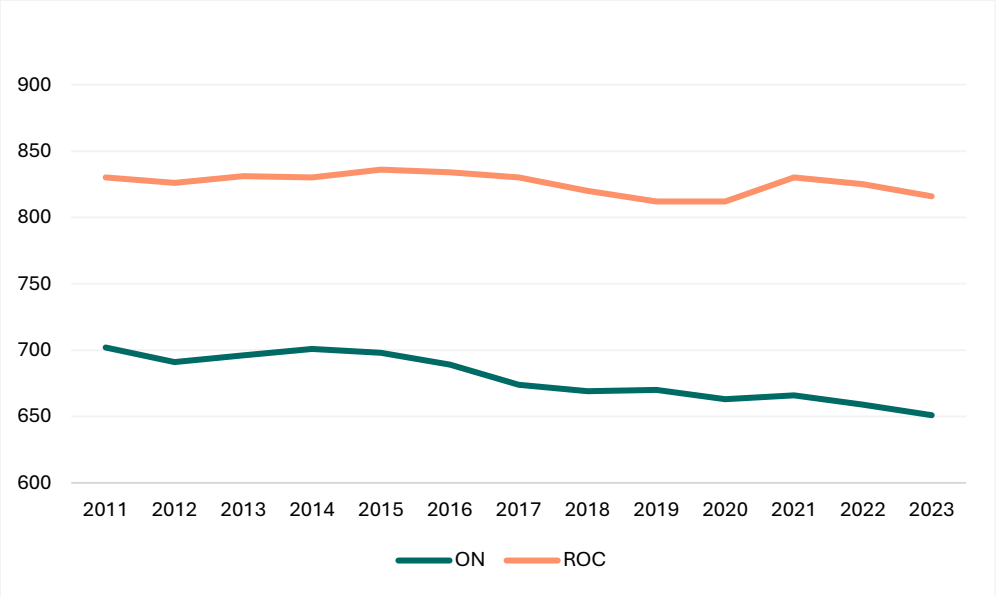
[347] Canadian Institute for Health Information, "Patient Harm in Canadian Hospitals? It Does Happen."
[348] Office of the Auditor General of Ontario, "Value-for-Money Audit: Emergency Departments."

control over their lives. Overtime, sick time, and vacancy rates are on the rise. Nurses are struggling – and when they do, the health system suffers.

Despite government claims of progress, their own projections confirm the crisis: Ontario faces a shortage of 33,200 nurses by 2032.[349] Rather than investing in retention, recruitment, and nursing careers pathways, the government has relied on "staffing flexibility" measures and the expansion of private, for-profit care – weakening the system further. Urgent action is needed to rebuild the nursing workforce – the Ontario government and health system employers must act now to strengthen nursing careers and address the crisis.

A rich body of evidence demonstrates that RN care improves patient outcomes, enhances patient experience, and reduces health system costs. RNAO's scoping review of 70 years of research confirms that RN care consistently improves quality indicators, including reduced mortality and morbidity rates.[350] Yet, RN understaffing remains a long-standing problem – the result of misguided policies that have eroded RN workforce numbers. Ontario has trailed the rest of Canada in RN staffing for more than three decades and is currently short nearly 26,000 RNs on a per-capita basis.[351]

Figure 30: RNs per 100,000 population: Ontario vs rest of Canada, 2011–2023[352]



[349] Jones, "Ontario Will Need Tens of Thousands of New Nurses, PSWs by 2032."
[350] RNAO, "Backgrounder: 70 Years of RN Effectiveness."
[351] RNAO, "CIHI Data Reveals Critical Nursing Shortage in Ontario."
[352] Canadian Institute for Health Information, "Registered Nurses"; Statistics Canada, "Statistics Canada. (2022). Population Estimates on July 1st, by Age and Sex. Table: 17-10- 0005-01 (Formerly CANSIM 051-0001). December 21, 2022"; RNAO calculation.

For many years, RNAO has sounded the alarm on the dangers of inadequate RN staffing, backed by extensive research. Ontario's long-standing RN shortage problem has escalated into a human resources crisis, further magnified by the COVID-19 pandemic. RNAO conducted and collaborated on multiple surveys throughout the pandemic to assess its impact on the nursing workforce:

2021: *Work and Wellbeing Survey Report*:[353]

- RNAO surveyed more than 2,100 respondents to understand the impact of COVID-19 on RNs, NPs, and nursing students in Ontario.
- Ontario risks losing more than 20 per cent of early-career RNs/NPs (26 to 35 years old).
- 70 per cent of RNs/NPs working excessive overtime planned to work fewer hours post-pandemic.

2022: *Nursing Through Crisis: A Comparative Perspective*:[354]

- During the peak of the pandemic's third wave in 2021, RNAO surveyed nurses across Canada to learn about pandemic impacts. This report compares results of RNAO surveys conducted in 2021 and 2022 with similarly focused national and international surveys.
- More than 75 per cent of survey participants were burnt out, describing themselves as both exhausted and disengaged.
- Of the 69 per cent of nurses who plan to leave their positions in the next five years, 42 per cent plan to leave the nursing profession altogether, whether by retiring or seeking employment in a field other than nursing.

2021: The Healthy Professional Worker (HPW) Partnership:

- Led by Dr. Ivy Bourgeault of the University of Ottawa, this partnership surveyed seven professions, including nursing, to compare the effects of the pandemic across professions.
- Nurses demonstrated the highest intention to leave, with 39 per cent having thought about leaving their health-care facility and 31 per cent thinking about leaving the profession.
- About 90 per cent of respondents experienced at least moderate stress, with mid-career RNs/NPs reporting the highest levels of stress. Nurses and midwives demonstrated the greatest decrease in mental health, and burnout rates were the highest among nurses.

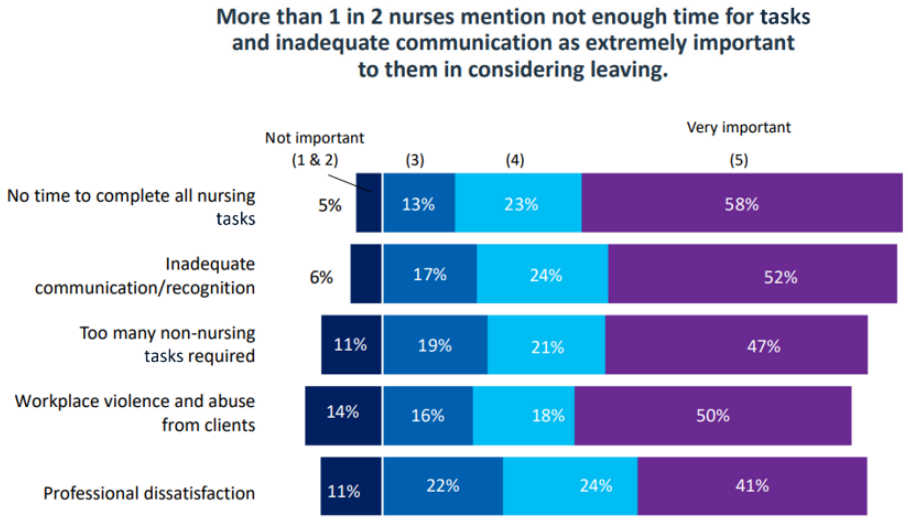
[353] RNAO, *Work and Wellbeing Survey Results*.
[354] RNAO, *Nursing through Crisis: A Comparative Perspective*.

2024: Canadian Federation of Nurses Union (CFNU) online survey of 5,595 nurses practicing in Canada.[355] The results revealed that nurses continue to struggle in the post-pandemic context, as evidenced by many metrics:

- **Burnout:** 9 in 10 nurses demonstrated evidence of burnout, up from 2023.
- **Increased demands:**
    - 7 in 10 nurses indicated that their workplace is regularly overcapacity.
    - 7 in 8 nurses have cited working overtime over the past year.
    - 57 per cent of respondents feel their safety is at risk after working for longer than 12 hours.
- **Deteriorating quality of care:**
    - 56 per cent of respondents said the quality of care at their workplace deteriorated over the last year.
    - 1 in 2 nurses reported that they experienced a near miss or patient safety concern within the past 6 months, due to understaffing.
- **Turnover intention:**
    - 4 in 10 nurses reported an intention to leave the profession/their job or retire in the next year.
    - 7 in 10 nurses cite staffing and workload as extremely important factors in considering leaving.
    - More than 50 per cent of nurses report that insufficient time for tasks and inadequate communication/recognition are extremely important to them in considering leaving.
- **Agency work:**
    - 1 in 3 nurses are interested in agency work or increasing the amount of agency work they do.
    - Nearly half of new grads are interested in agency work.
    - 7 in 10 nurses cite better pay as their main reason for being interested in agency work.
    - Nurses who have no burnout symptoms (67 per cent), no anxiety (49 per cent) and no depression (48 per cent) – and nurses from units that are not over capacity (53 per cent) – are most likely to say they are not at all interested in agency work.

[355] The Canadian Federation of Nurses Unions, “CFNU Member Survey Report.”

Figure 31: Nurses' turnover intention, 2021–2024[356]



Promising interventions

Addressing racism and discrimination within the nursing profession

As a response to RNAO's tireless calls for race-based data collection and following RNAO's *Black Nurses Task Force Report*[357], the College of Nurses of Ontario released an inaugural workforce census in 2024. The goal of this census was "to give Ontario's health system the data it needs to address diversity, equity and inclusion issues nurses face, and focus on areas requiring attention." The results of the first report, *Demographics and Nursing Practice (2024)*, demonstrate key disparities and challenges for equity-deserving groups[358]:

- **Leadership roles in nursing:** There is an under-representation of NPs, RPNs, respondents who identified as 2SLGBTQI+ or with a disability in leadership roles. There were also disparities in leadership roles observed across races, with a greater prevalence of white nurses in leadership roles, compared to racialized nurses.
- **Educator roles in nursing:** Educators were disproportionately women, domestically educated, RNs, heterosexual and white.
- **Unequal access to workplace accommodation:** Respondents who were internationally educated nurses, another gender or men, NPs or 2SLGBTQI+, did not receive workplace accommodations as often as individuals in other groups. Moreover,

[356] The Canadian Federation of Nurses Unions.
[357] RNAO, *Black Nurses Task Force Report: Acknowledging, Addressing and Tackling Anti-Black Racism and Discrimination Within the Nursing Profession*.
[358] College of Nurses of Ontario, "Workforce Census: Demographic and Nursing Practice Report."

Black, East Asian, mixed-race, and South Asian nurses also did not receive workplace accommodations as often as the full sample average.

- **Seeking nursing employment:** Racialized respondents disproportionately reported they were seeking nursing employment compared to white respondents.

These preliminary survey results reveal shocking concerns related to racism and discrimination in the nursing profession and align with many of the concerns voiced in RNAO's *Black Nurses Task Force Report*. Targeted retention and recruitment efforts are urgently needed to increase equity, diversity, and inclusion in the nursing profession. To address these concerns RNAO established the Health Equity Consortium and is developing the *Addressing Anti-Black Racism in Nursing* BPG (set for release in February 2026). This guideline will focus on creating evidence-based guidance to help eliminate anti-Black racism in nursing and improve belonging, wellbeing, and retention of Black nurses across all sectors. We expect to publish the guideline in February 2026.

Healthy Work Environments best practice guidelines

RNAO's focus remains to address the nursing crisis in Ontario with evidence-based interventions. In RNAO's 2000 report, *Ensuring the Care Will Be There: Report on Nursing Recruitment and Retention in Ontario*[359], RNAO recommended developing guidelines for creating healthy work environments for nurses to stabilize and strengthen the nursing profession in Ontario. The resulting Healthy Work Environments (HWE) Best Practice Guidelines (BPG) Program was launched in July 2003, with funding from the then Ontario Ministry of Health and Long-Term Care. It augments RNAO's world renowned clinical BPG program, launched in 1999. RNAO has since published 12 HWE BPGs, widely used across Ontario, nationally and internationally. HWEs are defined as environments that maximize the health and wellbeing of nurses and other members of the interprofessional team, improve patient outcomes and enhance organizational performance. RNAOs 12 HWE BPGs provide evidence-based recommendations and implementation strategies to help health and social service organizations create and sustain healthy work environments. They cover leadership, collaborative practice, workload and staffing, professionalism, embracing diversity, and workplace health, safety and wellbeing.

The foundation for all HWE BPGs is a conceptual HWE model designed to identify and understand the multiple factors, relationships and synergies amongst work environments, nurses and other health providers.[360] This model views a healthy workplace as the result of interdependence among three levels or "determinants": individual (micro), organizational

[359] RNAO, "Ensuring the Care Will Be There: Report on Nursing Recruitment and Retention in Ontario."
[360] Tucker et al., "A Conceptual Model for Healthy Work Environments for Nurses."

(meso) and external (macro) system.[361] Recent research has identified additional contextual domains, core attributes and features that further clarify how context influences the implementation of evidence-based practice.[362] Exploring these elements brings us closer to creating work environments that support the health and wellbeing of interprofessional teams, patients and caregivers.

Implementation activities continue to shape the growth of RNAO's HWE BPGs to strengthen the nursing workforce. In a four-year longitudinal time-series study, six foundational HWE BPGs were implemented across three teams within each of nine health-care sites, representing acute care, long-term care, mental health and community care nurse settings. Nurses reported improvements in their nursing practice, work environments, and patient outcomes.[363] Qualitative data further showed that nurses highly valued the focus on HWE BPGs and found the recommendations well suited to their workplace context.[364]

Ontario's leadership in evidence practice is well established and respected by nurses, patients and interprofessional teams. RNAO continues to urge the government to fund the development of additional guidelines and resources to support healthier workplaces for health professionals.

Recommendation C2: Nurse compensation

Ensure fair compensation for nurses by increasing pay, harmonizing wages upwards to address sector disparities, and aligning with competing jurisdictions.

Action items

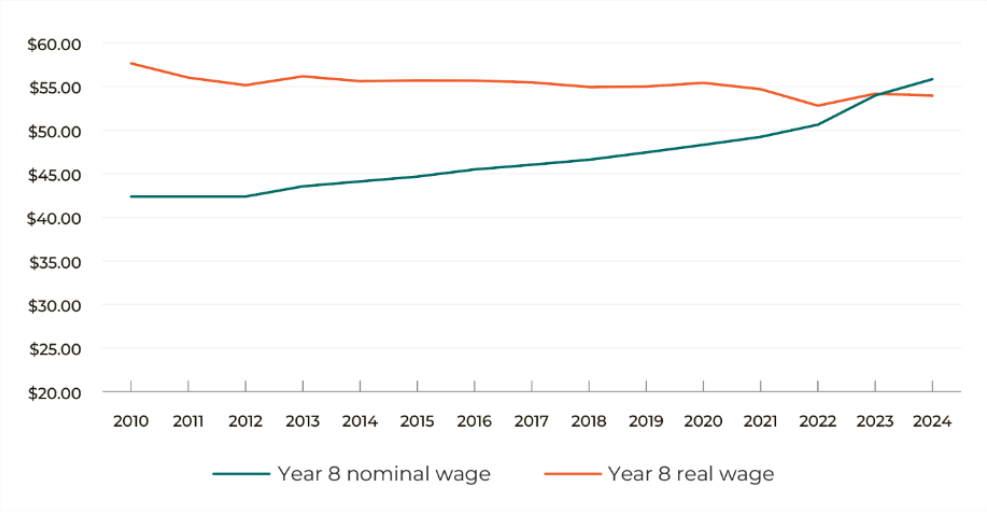
- Increase compensation for nurses working in all roles, domains and sectors.
- Harmonize compensation upwards to address pay disparities affecting primary care, home care, and long-term care.
- Guarantee competitive compensation for nurses comparable to other jurisdictions, such as the United States.

[361] Tucker et al.
[362] Squires et al., "The Implementation in Context (ICON) Framework."
[363] Nickerson-White, *Pilot Evaluation of Implementation and Update of Healthy Work Environment Best Practice Guidelines*.
[364] Nickerson-White.

Rationale

Nurse retention and recruitment initiatives must prioritize improved compensation to succeed. Several studies cite compensation as a key factor influencing RN retention and recruitment across sectors.[365] Yet, nurses today earn less in real terms than they did in 2010.[366]

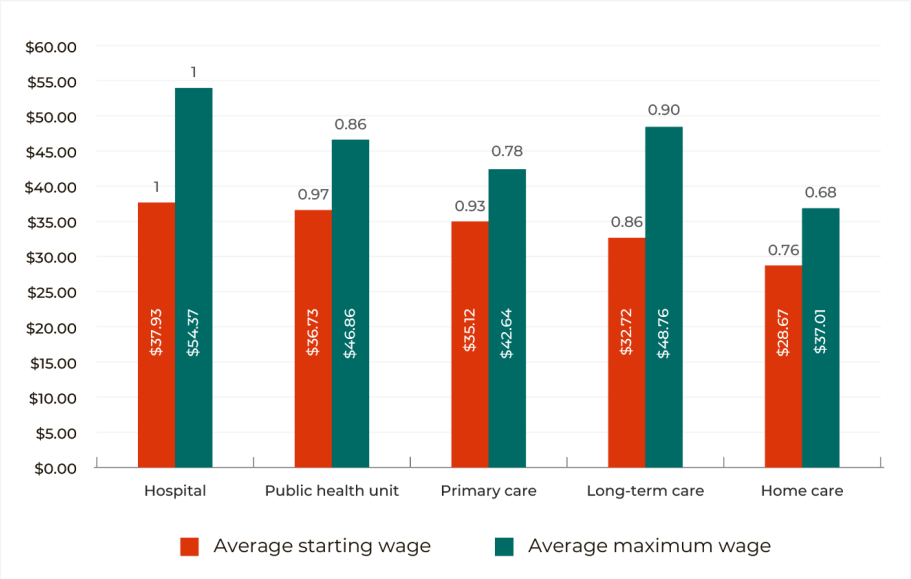
Figure 32: ONA-OHA year 8 nominal wage vs. real wage (constant 2023$) projected to 2024 with inflation forecast[367]



Significant wage disparities persist between sectors, with hospital RNs earning considerably more than their counterparts in the community. RNAO's analysis of unionized full-time RNs shows hospital RNs earn consistently higher hourly wages despite equivalent education. By 2023, home care and primary care RNs earned, on average, just 68 cents and 78 cents respectively for every dollar earned by hospital RNs. Home-care RNs were particularly disadvantaged across the full wage grid.

[365] Long-Term Care Staffing Study Advisory Group, "Long-Term Care Staffing Study"; Eckler, "Ontario Community Health Compensation Market Salary Review"; RNAO, "Political Action Bulletin: The RN Crisis in Ontario."
[366] RNAO, "Political Action Bulletin: The RN Crisis in Ontario."
[367] Government of Canada, "Consumer Price Index, Annual Average, Not Seasonally Adjusted"; Ontario Nurses' Association, "Find Your Contract"; RNAO calculation. **Note:** RNAO's analysis relies on year-8 wage rates of ONA-represented RNs as a proxy for nurse wages, per the above chart.

Figure 33: RN hourly wage rates and ratios across sectors in 2023[368]



Recent wage settlements have widened these gaps. Hospital RNs received an average 11 per cent wage increase over two years[369], while home-care RNs saw increases of only 3–4.6 per cent.[370] This disparity makes retention in home care increasingly difficult.

In 2023, a market study recommended that maximum wages for primary care RNs range from $49.44 to $52.97 per hour.[371] However, collective agreement data shows primary care RNs earned 14 per cent to 20 per cent less than this recommended wage. Wage growth potential also varies sharply: hospital RNs could see a 43.34 per cent increase from starting to maximum wage, while primary care and home care RNs could expect just 21.42 per cent and 29.09 per cent growth, respectively.

Without addressing these inequities, nursing retention and recruitment will continue to falter, driving nurses toward agency work. Compensation disparities also undermine health system transformation consistent with the ECCO model, perpetuating system instability and misalignment. Unsurprisingly, Ontario's RN deficit increased by around 3 per cent in 2023, with the community health sector experiencing a 4.4 per cent increase in RN deficit.[372]

[368] Ministry of Labour, Immigration, Training and Skills Development of Ontario, "Ministry of Labour, Immigration, Training and Skills Development of Ontario's Collective Bargaining Interactive Search"; Ontario Nurses' Association, "Find Your Contract", RNAO calculation.

[369] Jones, "Ontario Hospital Nurses Awarded Average Raises of 11% over Two Years, Union Says."
[370] Ontario Community Support Association, "Bridging the Gap: Strengthening Ontario's Home and Community Services."
[371] Eckler, "Ontario Community Health Compensation Market Salary Review."
[372] Canadian Institute for Health Information, "Registered Nurses"; RNAO, "CIHI Data Reveals Critical Nursing Shortage in Ontario"; RNAO, "Political Action Bulletin: The RN Crisis in Ontario."

D. Health system transformation

Recommendation D1: Primary care networks

Strengthen primary care leadership, coordination and social service integration in OHTs to improve patient care.

Action items

- **Establish leadership roles for PCNs:** Primary care networks (PCNs) should be given a leadership role within each OHT to ensure that health care remains community-based and anchored in primary care.
- **Ensure PCN representation on OHT boards:** Each OHT's coordinating corporation board of directors should include one nurse practitioner (NP) and one physician to represent PCNs.
- **Enhance care coordination in primary care:** OHTs should embed care coordination and system navigation within primary care to improve patient experience and service delivery.
- **Integrate social services into PCNs:** OHTs should incorporate social services within PCNs to better address the social determinants of health and enhance comprehensive patient care.

Rationale

More than one in six Ontarians – an estimated 2.5 million people – do not have a family physician or nurse practitioner they see regularly, according to one survey.[373] That's a dramatic increase since 2020 when Statistics Canada estimated only 1.8 million people living in Ontario did not have a regular health-care provider.[374] Equally troubling is the forecast that by 2026, approximately 4.4 million Ontarians will lack a primary care provider.[375]

The initiative to establish primary care networks (PCNs) arises from concerns expressed by primary care providers within OHTs. These providers have highlighted the growing challenges they face in helping patients navigate the health-care system and connect with the clinical supports they require. The goal of PCNs is to connect, integrate and support primary care providers within OHTs to enhance the delivery and coordination of patient care. Within the OHT framework, PCNs have two main objectives: to organize the local primary-care sector

[373] Inspire-PHC, "Primary Care Data Reports."
[374] Inspire-PHC, "Primary Care Data Reports."
[375] Ontario Medical Association, "Every Ontarian Needs a Family Doctor."

in OHT planning and ensure a voice in OHT decision-making; and to act as a vehicle for supporting OHTs in implementing both local and provincial priorities.[376]

PCNs must assume leadership in HST due to their central role in health-care delivery, support in population health management and integrated approach to patient care. Given that primary care serves as the gateway to the health-care system,[377] the government has ascribed to them the important role of supporting OHT clinical change management and population health management approaches.[378] Interprofessional primary care teams are also uniquely positioned to best respond to local needs and populations, promote equity and improve health and social service access for marginalized populations.[379]

While all OHTs must include primary care providers organized within a PCN to participate in decision-making process and improving health access for patients[380], RNAO is of the view that the coordinating corporation of every OHT should require that at least two voting members of the board of directors – one NP and one physician – be selected by the primary care network.[381] 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 coordinating corporations within OHTs.[382] Ontario's health system and its 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.[383]

In particular, the involvement of NPs in HST must substantially increase.[384] Publicly funded, team-based models of care including NPs as valued members of primary-care teams have shown excellent results on multiple quality metrics such as improved patient satisfaction, enhanced quality of care, and lower costs.[385] NPs are excellent health system navigators; to

[376] Ontario Ministry of Health, "Primary Care Networks in Ontario Health Teams: Guidance Document."
[377] Misra et al., "Prioritizing Coordination of Primary Health Care."
[378] Ontario Ministry of Health, "Primary Care Networks in Ontario Health Teams: Guidance Document."
[379] RNAO, "Submission Re Proposed New Regulation under the Connecting Care Act, 2019."
[380] Ontario Ministry of Health, "Primary Care Networks in Ontario Health Teams: Guidance Document";
[381] RNAO, "Submission Re Proposed New Regulation under the Connecting Care Act, 2019."
[382] Ayodele Odutayo, Jeremy Petch, and Andreas Laupacis, "Health Care in Ontario: A Primer for The Board of Directors of Community Governed Primary Health Care Organizations."
[383] Ghavamabad et al., "Establishing Clinical Governance Model in Primary Health Care"; , "Submission Re Proposed New Regulation under the Connecting Care Act, 2019"; Ontario Ministry of Health, "Primary Care Networks in Ontario Health Teams: Guidance Document."
[384] RNAO, *Nurse Practitioner Task Force: Vision for Tomorrow*.
[385] Contandriopoulos et al., "Pre-Post Analysis of the Impact of British Columbia Nurse Practitioner Primary Care Clinics on Patient Health and Care Experience"; Contandriopoulos et al., "Evaluating the Cost of NP-Led vs. GP-Led Primary Care in British Columbia"; DiCenso and Bryant-Lukosius, "Clinical Nurse Specialists and

best serve the health needs of underserved populations, they must be given cross-sector privileges within OHT boundaries.[386]

Vulnerable people – especially those with higher illness burdens due to poverty, health co-morbidities, mental illness and other social and environmental inequities – also need access to robust team-based care that provides links to social services. With the goal of coordinating and navigating the care pathways for the attributed population, social services integration in PCNs will support OHTs in implementing local priorities by improving the economic and social wellbeing of the population through reciprocal, preferential and mutually supportive decision-making.[387]

For a broader discussion of navigation and care coordination, see *Recommendation B2: Integrated and coordinated care*, page 85).

Recommendation D2: Mental health and addiction networks

Engage mental health and addiction (MHA) networks in OHT planning and decision making.

Action items

- Invest in an integrated substance use model of care across all health-care settings by allocating existing and, if required, additional funds from the Road to Wellness plan.
- Link provincial mental health and addiction priorities to local OHT development.
- Facilitate integration of MHA services across sectors with a particular focus on direct navigation from primary care to local or regional mental health and addiction services.

Rationale

Mental health services in Ontario face significant challenges, reflecting broader national issues. Fewer than half of Canadians who sought help for mental health concerns received services,[388] with those experiencing mental health conditions reporting higher cost barriers and greater financial distress than others. The range of MHA services is complex, involving a wide variety of regulated health professionals, including nurses. These services must span the full continuum of care, from community care to acute care.[389] However, MHA services in Ontario are fragmented and poorly coordinated, with inequitable access. They include

Nurse Practitioners in Canada: A Decision Support Synthesis"; Maier, Aiken, and Busse, "Nurses in Advanced Roles in Primary Care."

[386] RNAO, *Nurse Practitioner Task Force: Vision for Tomorrow*.

[387] Mitterlechner, "Leadership in Integrated Care Networks"; Bhuiya et al., "Examining the Intersections between Ontario Health Teams and Broader Human Services"; RNAO, "Submission Re Proposed New Regulation under the Connecting Care Act, 2019."

[388] Canadian Institute for Health Information. (2020). *Commonwealth Fund Survey, 2020*.

[389] RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians."

private, for-profit and unregulated services alongside in-patient and community-based settings, as well as health promotion and prevention programs offered by public health units.

Service availability is also insufficient for a province of more than 14 million people. For example, Ontario has only 32 Youth Wellness Hubs – essential access points for youth mental health, primary care and social services – across the province.[390] Recent government decisions to restrict harm reduction services, including plans to close 10 supervised consumption sites, means most Ontarians will have no access to these life-saving services in the province's toxic drug crisis. Despite securing $1.9 billion in matching federal funding through the Road to Wellness strategy, the provincial government has failed to address this crisis, which has claimed more than 22,000 lives since 2018. The Auditor General also reported that the province's Centre of Excellence for Mental Health and Addiction lacks reliable data on service availability and quality, hindering effective planning and care for people with opioid addictions.[391]

This disjointed system creates enormous barriers to receiving the right care, in the right place, at the right time,[392] complicating both navigation and care coordination. The consequences are evident in worsening outcomes:

- Deteriorating self-rated reports of mental health from 2019 to 2022, with Ontario faring poorly against other jurisdictions in Canada.[393]
- Increasing prevalence of suicidal ideation between 2019 and 2021.[394]
- A steady rise in drug toxicity deaths, with opioid-related mortality doubling over the pandemic.[395]
- Persistent high rates of emergency department visits and hospital admissions related to mental health and substance use since 2020.[396]

To address these challenges, MHA services within OHTs must:

- Be internally networked to facilitate navigation and care coordination.
- Be connected with services outside the OHT to support comprehensive care pathways.
- Be universally accessible across all health sectors and social services.

[390] Youth Wellness Hubs Ontario, "About Youth Wellness Hubs Ontario."
[391] Office of the Auditor General of Ontario, "Implementation and Oversight of Ontario's Opioid Strategy."
[392] Government of Ontario, "Ontario Expanding Mental Health Services for Children and Youth in Every Corner of the Province."
[393] Government of Canada, "Self-Rated Mental Health by Gender, Geographical Region and Age Group, Canada, Excluding the Territories."
[394] Statistics Canada, "Prevalence of Suicidal Ideation among Adults in Canada."
[395] Public Health Ontario, "Substance Use and Harms Tool."
[396] ICES, "Mental Health Dashboard."

A promising example is the partnership between Bayshore HealthCare and Waypoint Centre for Mental Health Care. Their at-home program provides 8 to 16 weeks of specialized MHA services for individuals post-hospital discharge, delivered by MHA specialists, nurses, and other health professionals.

Primary care must also be central to MHA integration. As the primary entry point for most Ontarians, primary care plays a crucial role in early identification and management of mental health needs, while simultaneously managing co-morbid medical conditions.[397] Strengthening the integration between MHA and primary care is essential for timely, effective, and equitable access to services.

Recommendation D3: Funding to promote the Quintuple Aim

Ontario's health system should fund OHTs in ways that advance the Quintuple Aim:

- Improving the patient experience.
- Enhancing patient and population health outcomes.
- Controlling costs.
- Supporting better provider experiences.
- Promoting health equity (fair access and outcomes for everyone).

Action items

- **Focus on equity when counting people:** Make sure the method used to decide how many people each OHT serves (attributed population) is accurate and includes everyone, especially individuals who struggle with accessing or don't regularly use health services.
- **Use risk adjustors that reflect real-life factors:** When estimating health costs, include details like age, existing health conditions, socioeconomic status and other relevant factors, so OHTs can provide appropriate care for diverse populations.
- **Define care bundles clearly:** Some health conditions will be funded through a "bundle," which means one single payment covers all care for the condition (like diabetes or heart failure). These bundles should be clear on what's included to make sure care is properly coordinated and nothing major gets left out.
- **Pooled funding for health and social services:** Better coordinate health care (e.g., hospitals, primary care provider, home care) with social services (e.g., housing, mental health supports) by combining traditionally separate funding sources. This helps address the many factors that impact health, such as housing or income.

[397] Moroz, Moroz and D'Angelo, "Mental Health Services in Canada"; Ontario Medical Association et al., "Strengthening the Delivery of Mental Health and Addiction Services in Primary Care."

- **Adopt double-sided shared savings:** When OHTs lower costs without compromising quality, they share in the savings. But if costs go over planned amounts, each entity of the respective OHT needs to share the percentage of the additional costs incurred. This helps encourage smarter spending and greater collaboration.
- **Encourage providers to join OHTs:** Offer incentives such as additional funding or resources so doctors, nurse practitioners, nurses, and other professionals are motivated to work within OHTs, making sure patients get properly coordinated care.
- **Introduce changes to payment methods gradually:** Move toward new ways of paying doctors and other providers slowly and in partnership with them. This helps avoid disruptions and builds trust.

Figure 34: Connecting the Quintuple Aim to the OHT funding formula[398]

Quintuple aim	RNAO's recommendations
Improved patient experience	Establish measurement of attributed populations with a focus on equity.
	Ensure precision while defining bundles for comprehensive care.
Improved patient and population health outcomes	Establish measurement of attributed population with a focus on equity.
	Ensure risk-adjustors reflect equity, ample population heterogeneity and fair pricing.
	Ensure precision while defining bundles for comprehensive care.
Lower cost of care	Consider pooled funding to integrate health care and social services better.
Improved provider experience	Double-sided shared savings must foster accountability across the OHT spectrum.
	Incentivize providers to join OHTs.
	Provider payment methods must ensure changes are made incrementally and collaboratively.
Advancing health equity	Establish attributed population measurement with a focus on equity.

[398] Table created by RNAO based on recommendations in this report.

	Ensure risk-adjustors reflect equity, ample population heterogeneity and fair pricing.

See also *HST progress to date*, page 17.

Rationale

Put patients first. Patients are the heart of Ontario's health system, and funding should be aligned with their needs to make sure care remains patient-centred. By focusing on the whole person – including medical, social and emotional factors – OHTs can help patients access the supports they need through one coordinated network. This also strengthens trust between patients and providers and cuts down on stress when navigating a complicated system.

In addition, having a clearer path to services means patients get care sooner, reducing the risk of problems getting worse over time. When patients feel like they're being heard and have a say in their care, the whole system benefits from lower costs, fewer avoidable hospital visits, and better long-term outcomes.

Improve overall health. A strong funding formula encourages OHTs to work together and focus on long-term health needs rather than just short-term solutions. For example, ensuring that people with chronic illnesses get consistent follow-up care and better preventive measures can lower complications down the road.

Because OHTs bring together multiple services, like primary care providers, hospitals and social support agencies, patients benefit from a wider range of options, leading to better outcomes at all stages of care.

By prioritizing population health goals, OHTs can also direct resources where they're needed most. An integrated approach makes it easier to track and respond to local health patterns – for example, making sure communities with higher rates of heart disease or diabetes get specialized support. This kind of targeted strategy can help address health issues earlier, preventing them from escalating and taking pressure off emergency services.

Use resources wisely: Setting up a funding system where OHTs share both savings and risks encourages providers to work efficiently without sacrificing quality. If an OHT can lower costs – by cutting down on unnecessary tests or hospital readmissions – they share the additional savings. But if expenses go over set targets, they take on part of the extra costs too. This "double-sided shared savings" model helps keep everyone focused on making the best decisions for patients by fostering mutual accountability and making each rational entity work towards efficiency by reducing repetitive tests and unnecessary referrals. Using

funding more efficiently frees up resources for other critical areas, like mental health support or community-based services.

Plus, pooled funding for health and social services lets OHTs address the root causes of poor health – like bad housing or food insecurity. When resources are directed toward community-based supports that keep people healthier in the first place, the whole system benefits. Making sure that every person – no matter their background – has the opportunity for good health both an ethical responsibility and a smart strategy for reducing long-term costs.

Support health providers. Health providers – whether primary care physicians, nurse practitioners, or social service staff – are more likely to engage and collaborate when they feel included, properly compensated and valued for their skills. Slow, incremental payment changes that involve providers in the design process can help reduce disruptions and maintain trust. This way, new approaches – like paying for care coordination or rewarding preventive efforts – can be introduced step by step and adjusted based on real-world experience.

When providers work together in a team or network, patients get more coordinated support, and providers themselves benefit from clearer communication. Over time, this can help reduce administrative headaches and burnout, making for better morale among staff. Also, a payment system that accounts for the extra effort needed to coordinate across different sectors – like health, housing, and social services – encourages stronger connections between providers who might otherwise be working in isolation.

Advance equity. A solid funding formula also needs to help close health gaps. Adjusting funding to reflect factors like age, income, cultural background, location, and other key elements means OHTs can better support communities at higher risk for poor health outcomes. This helps make sure vulnerable or marginalized groups aren't left behind just because they don't see a doctor regularly or live in an area with fewer health-care resources.

See *Appendix C: Funding to promote the Quintuple Aim – the evidence*, page 139, for more specifics on addressing the action items outlined above.

Summary of recommendation

Altogether, these strategies help build stronger foundation for a healthier, more equal Ontario. By directing resources where they're needed most, encouraging collaboration among health and social service providers, and keeping patients at the centre, OHTs can deliver better outcomes for everyone. This comprehensive approach not only tackles immediate health-care needs but also sets up long-term improvements in the health system's performance. Making sure that the province stays committed to the Quintuple Aim

in a practical and achievable way means Ontario's health-care funding will work better for all residents in the years ahead.

E. Determinants of health

Recommendation E1: Fiscal effort and social determinants of health

Increase the fiscal effort of government to address the social determinants of health, with an immediate focus on housing and food and income security, particularly rates under Ontario Works and the Ontario Disability Support Program.

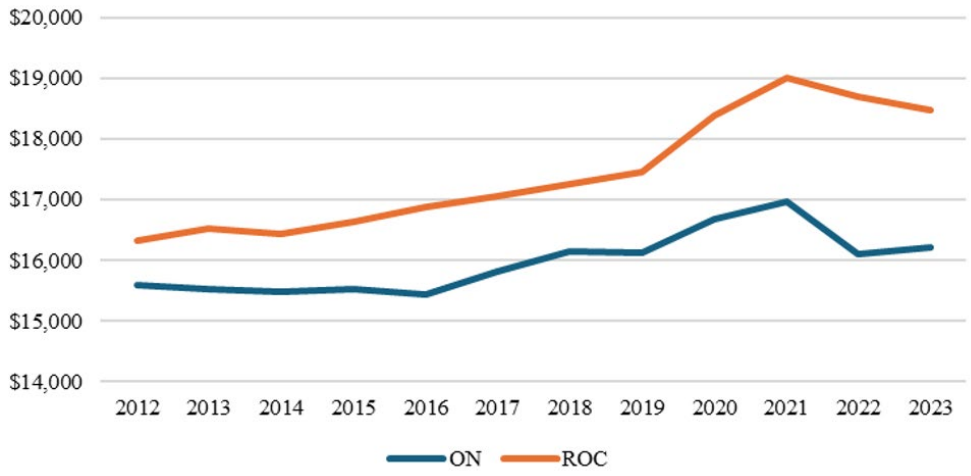
Action items

- Invest one per cent of the provincial budget annually in accessible, affordable housing programming to address the province's housing shortage and homelessness.
- Strengthen tenant rights, cap rent increases below the consumer price index and limit availability of above-guideline rent increases.
- Implement these and other measures in a comprehensive homelessness strategy that includes supportive housing, shelters and wrap-around services.
- Increase the minimum wage immediately to $19.60 per hour indexed annually to inflation.
- Immediately double provincial Ontario Disability Support Program (ODSP) and Ontario Works (OW) rates and index annually to inflation.

Rationale

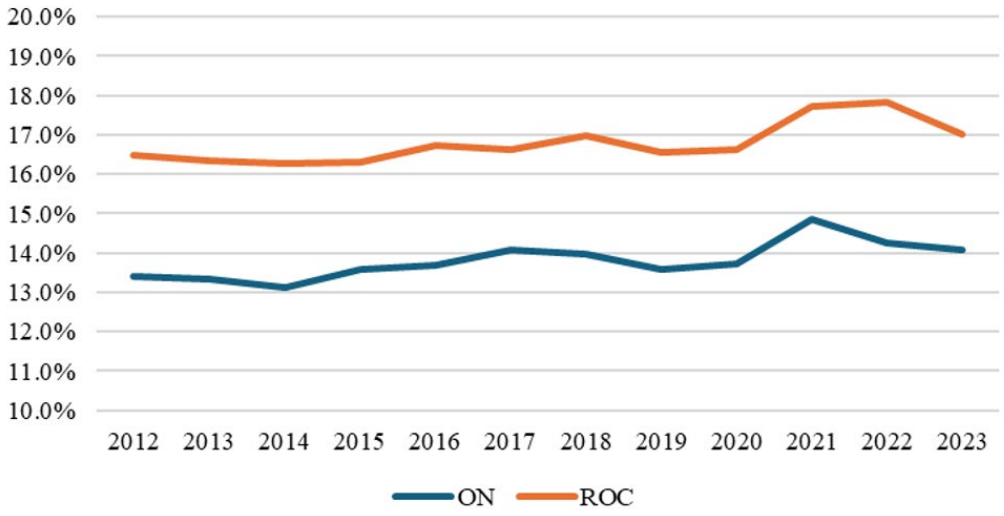
Ontario has consistently spent less on per capita public program spending than the rest of Canada over the last twelve years. The province's low ranking on public program expenditures per capita is matched by its relatively limited efforts at revenue generation.

Figure 35: Consolidated provincial-territorial and local governments public program spending (Constant 2023$) per capita[399]



Over the last 12 years, Ontario has ranked consistently as the lowest spender on public programming among all provinces except Alberta. Between 2022 and 2023, Ontario's own-source revenue as a share of GDP decreased by 0.2 percentage points.

Figure 36: Own-source revenue as a share of GDP (%)[400]



[399] Government of Canada, "Consumer Price Index, Annual Average, Not Seasonally Adjusted"; Government of Canada, "Canadian Classification of Functions of Government (CCOFOG) by Consolidated Government Component", March 30, 2016; Government of Canada, "Population Estimates on July 1, by Age and Gender"; and RNAO calculation.

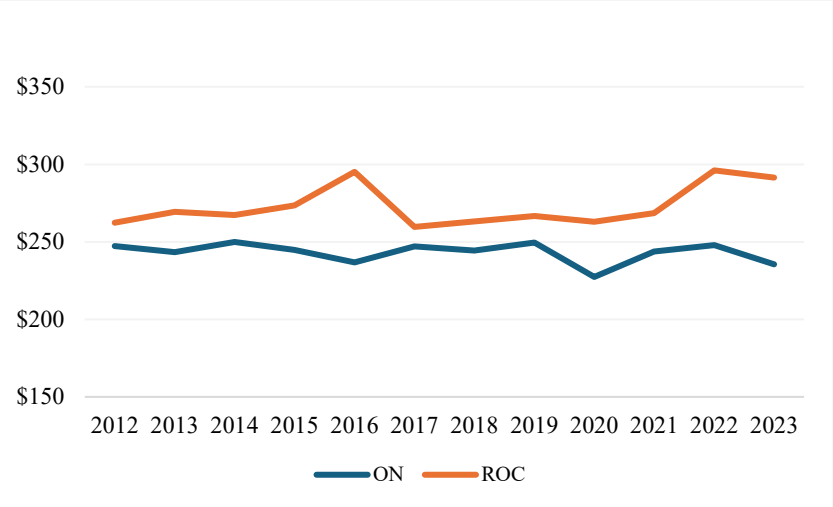
[400] Government of Canada, "Gross Domestic Product, Income-Based, Provincial and Territorial, Annual"; Government of Canada, "Canadian Government Finance Statistics for the Provincial and Territorial Governments" and RNAO calculation.

Ontario's fiscal effort will need to increase considerably to address the social determinants of health, as evidenced by the intersecting issues of housing status, and food and income security.

Housing is a determinant of health. It is also a human right – enshrined internationally since 1948 in the Universal Declaration of Human Rights, affirmed in the Canadian Human Rights Code since 1976, and embedded in Canadian legislation since 2019. Yet, the housing status of virtually all people in Canada is determined by their ability to participate in – and afford – what is available in a housing market that has become increasingly cruel over the years. Ontarians have been hit particularly hard by an escalating housing crisis marked by a significant housing shortage – especially in social housing – increased housing unaffordability, and a surge in homelessness.

Overall housing shortage: Ontario's population has increased rapidly over the past five years, but housing construction has not kept pace with this growth. The imbalance between supply and demand is evident in low vacancy rates – 2.5 per cent in Ontario and 1.9 per cent in Toronto for a two-bedroom rental unit in 2024 – well below the 3 per cent threshold that indicates a housing shortage.[401] The Ontario government has done little to address the shortage, spending 13 per cent less per capita than the rest of Canada over the past five years.

Figure 37: Consolidated provincial-territorial and local governments housing and community amenities spending (constant 2023$) per capita[402]



[401] Canada Mortgage and Housing Corporation, "Canadian Housing Survey Data Tables."
[402] Statistics Canada, "Consumer Price Index, Annual Average, Not Seasonally Adjusted"; Statistics Canada, "Canadian Classification of Functions of Government (CCOFOG) by Consolidated Government Component," March 30, 2016; Statistics Canada, "Population Estimates on July 1, by Age and Gender"; and RNAO calculation.

Social housing shortage: Despite early recognition of the need for public housing and additional subsidies, Canadian housing policy continues to rely almost exclusively on market mechanisms to supply, allocate and maintain housing stock. As a result, social housing represents only 3.5 per cent of Canada's total housing stock – half of the Organization for Economic Co-operation and Development and G7 average of 7 per cent and far below most developed countries.[403] Mirroring federal policy, Ontario has neglected social housing needs, focusing almost exclusively on market housing and home ownership. Funding for social and affordable housing has decreased significantly over time. Therefore, more than 100,000 households are on Ontario's social housing wait list, with many waiting over 10 years for placement.[404]

Figure 38: Number of social and affordable housing units by year of construction – Ontario[405]

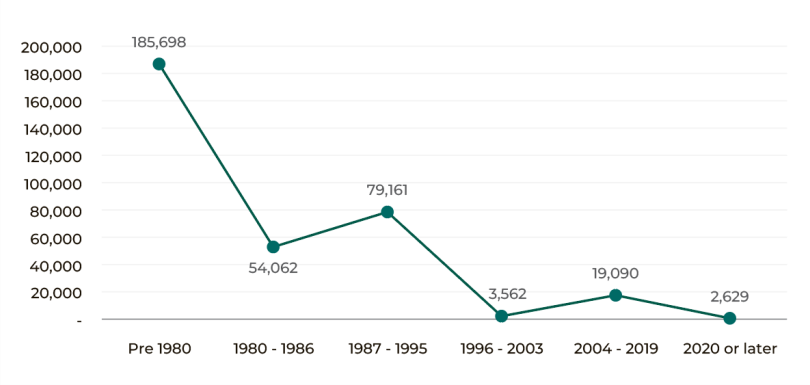
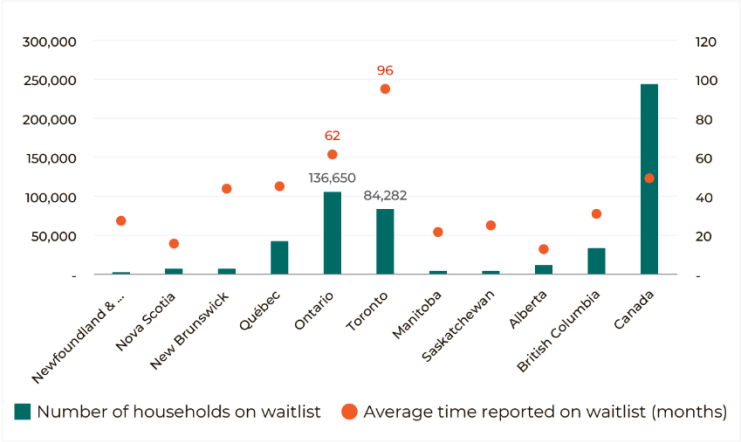


Figure 39: Ontario social housing demand[406]



[403] The Canadian Alliance to End Homelessness, PLACE Centre Smart Prosperity Institute, and REALPAC, "A Multi-Sector Approach to Ending Canada's Rental Housing Crisis."
[404] Canada Mortgage and Housing Corporation, "Canadian Housing Survey Data Tables."
[405] RNAO, "RNAO Fact Sheet: Housing, Health and Human Rights."
[406] RNAO.

Increased unaffordability

Skyrocketing rent: In Ontario, the average value of owner-occupied homes has increased significantly since 2016, contributing to the decline in homeownership.[407] Adults – especially young adults – increasingly rely on the rental market, but unaffordability is even more pronounced there.

Low vacancy rate: Severe supply-demand imbalances have driven low vacancy rates, creating high demand for limited rental units. Landlords, facing little competition, have been able to raise rents substantially.

Above guideline rent increases: In Ontario, the rent increase guideline only applies to rental units occupied before Nov 15, 2018.[408] Legislated exemptions for newer properties allow unrestricted rent increases, further undermining affordability.

Rental market loopholes: Vacancy decontrol allows landlords to raise rents without limits when a unit becomes vacant. This creates incentives to push out long-term tenants, worsening housing insecurity and unaffordability.

These conditions have driven skyrocketing rent increases. Coupled with the growing gap between income growth and rent hikes, this has significantly worsened housing affordability.

Income: Rent increases have far outpaced average wage growth in Ontario and greatly exceeded increases in minimum wage and social assistance.

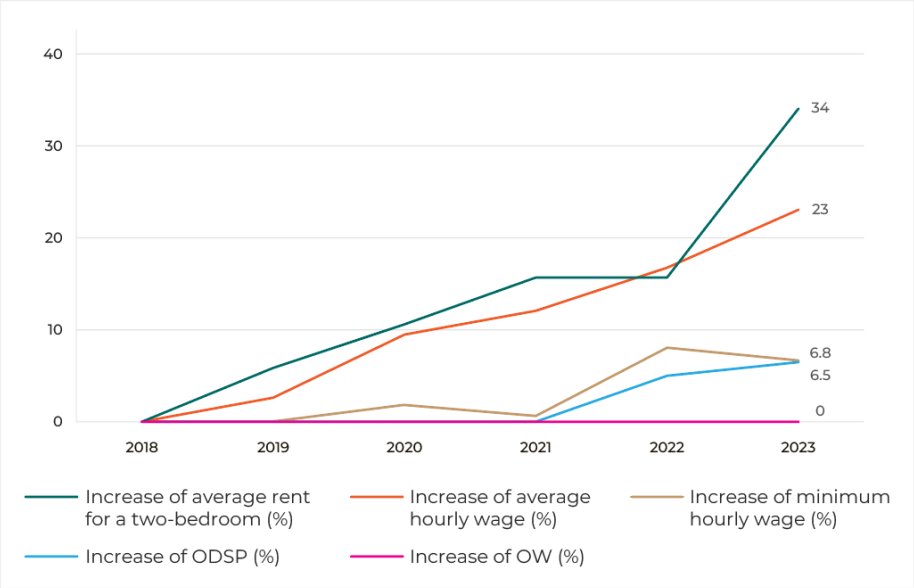
Minimum wage: In Ontario, the wage needed to afford a two-bedroom apartment is more than twice the minimum wage ($17.20 in 2024).[409] The average rent for a studio apartment accounts for approximately two-thirds of a minimum wage earner's monthly income – well above the affordability threshold of 30 per cent.[410]

Social assistance: Social assistance – Ontario Works (OW) and the Ontario Disability Support Program (ODSP) – is the primary income source for individuals who are homeless or at high risk of homelessness.[411] OW rates have remained unchanged since 2018, despite rising rents and inflation. Although ODSP indexing began in 2023, rates have not kept pace with rent increases.[412] In 2024, monthly OW and ODSP rates for a single person are $733 and

[407] Statistics Canada, "The Daily — To Buy or to Rent."
[408] Government of Ontario, "Residential Rent Increases."
[409] Macdonald and Tranjan, "Out-of-Control Rents: Rental Wages in Canada, 2023."
[410] Rentals.ca, "Apartments, Condos and Houses for Rent Across Canada."
[411] Office of the Auditor General of Ontario, "Value for Money Audit: Homelessness."
[412] Government of Ontario, "Ontario Disability Support Program."

$1368 respectively,[413] while the average rent for a studio apartment in Ontario is $1,837 per month.[414]

Figure 40: Increase of average rent, average hourly wage, minimum wage, ODSP and OW[415]



Food insecurity: Inadequate minimum wage and insufficient social assistance have worsened housing affordability and also food insecurity. Increased housing expenses force many to cut back on groceries and other basic needs. Food bank usage has surged. Between April 1, 2023, and March 31, 2024, more than one million unique individuals visited a food bank in Ontario, making nearly 7.7 million visits.[416] This unprecedented demand has strained resources, leaving many food banks unable to meet the growing need.

A 2022–23 food bank visitor survey revealed that over two-thirds of respondents had less than $100 left each month after paying for housing, and 22 per cent reported housing costs exceeded their monthly income.[417]

As food bank reliance grows, the demographic of users are shifting. While OW and ODSP recipients – forced to survive on unliveable incomes – remain the majority of visitors (29.3 per cent and 29.5 per cent, respectively), nearly one in four food bank users now cite employment as their primary source of income.[418]

[413] Income Security Advocacy Centre, “Social Assistance Rates - Income Security Advocacy Centre.”
[414] Rentals.ca, "Apartments, Condos and Houses for Rent Across Canada.”
[415] RNAO, “RNAO Fact Sheet: Housing, Health and Human Rights.”
[416] Feed Ontario, “Hunger Report 2024: Unravelling at the Seams.”
[417] Feed Ontario, “Hunger Report 2023: Why Ontarians Can’t Get Ahead.”
[418] Feed Ontario, “Hunger Report 2024: Unravelling at the Seams.”

Homelessness

The housing crisis paints a grim picture: rent inflation has far outpaced earnings, leaving one in four tenant households in Ontario living in unaffordable housing.[419] Many must sacrifice basic needs like food just to stay housed, while homelessness rises sharply.

From 2018 to 2022, Canada saw a 20 per cent increase in homelessness and an 88 per cent rise in unsheltered homelessness, based on point-in-time counts in 67 communities.[420] In Ontario, social housing shortages and long waitlists put social recipients at high risk of homelessness. As of July 2024, 26,553 ODSP and OW recipients were experiencing homelessness – nearly double the figure from two years earlier.[421] This highlights the inadequacy of social assistance amid Ontario's housing crisis.

Housing insecurity, income inadequacy, and food insecurity intersect, exacerbating existing health disparities and worsening health inequities.

Housing as a determinant of health

Housing instability and precarity jeopardize physical and mental health and wellbeing. The consequences include overcrowding, frequent relocation, eviction and – often – homelessness.

Overcrowding	Frequent relocation	Homelessness
• Faster and broader spread of communicable disease[422] • Asthma and lung problems related to mould or environmental factors[423]	• Various behavioural and emotional problems during formative years [425], including: ○ Poor emotional adjustment	• Increased risk of premature death, mental illness and substance misuse[426] • Increased risk of infections • Barriers to health-care access

[419] Canada Mortgage and Housing Corporation, "Canadian Housing Survey Data Tables"; Statistics Canada, "Dimensions of Core Housing Need, by Tenure Including First-Time Homebuyer and Social and Affordable Housing Status."
[420] Infrastructure Canada, "Housing, Infrastructure and Communities Canada - Everyone Counts 2020-2022 – Results from the Third Nationally Coordinated Point-in-Time Counts of Homelessness in Canada."
[421] Pinkerton and Hauen, "Number of Homeless OW, ODSP Recipients Has Almost Doubled in Two Years."
[422] City of Toronto, "Housing and Health: Unlocking Opportunity"; Hwang et al., "Housing and Population Health: A Review of the Literature."
[423] Stephen Hwang et al., "Housing and Population Health: A Review of the Literature."
[425] Waterston et al.; Jelleyman and Spencer, "Residential Mobility in Childhood and Health Outcomes."
[426] Forchuk et al., "Community Stakeholders' Perceptions of the Impact of the Coronavirus Pandemic on Homelessness in Canada."

• Poor child and youth mental health leading to aggressive behaviour, diminished health and reduced school performance[424]	○ Increased teenage pregnancy rates ○ Earlier onset of drug-related problems ○ Depression	• Reliance on emergency department services for care and, at times, shelter[427]

Existing social and economic inequities have deepened

Research shows that people experiencing homelessness (PEH) – the most extreme form of housing insecurity – face worsening health disparities, including increased risks of morbidity, mental illness, substance use, and premature death.[428] Economic disparity driven by low minimum wages and insufficient social assistance, often intersects with factors such as race, Indigenous identity, gender and disability. This results in the over-representation of these groups among the homeless population.[429]

Figure 41: Health impacts for people experiencing homelessness in Ontario[430]

7%	29%	17 years	93%
of PEH hospitalization is due to cellulitis	of PEH hospitalization due to substance use & mental illness	Average reduced life span	of PEH admitted to hospital via emergency department
Increased infection and mobidity	Increased mental illness	Increased mortality	Lack of access to primary care

[424] Waterston et al., "Housing Need in Canada."
[427] Booth et al., "Opioid-Related Overdose Deaths among People Experiencing Homelessness, 2017 to 2021."
[428] Forchuk et al., "Community Stakeholders' Perceptions of the Impact of the Coronavirus Pandemic on Homelessness in Canada."
[429] Alzheimer Society of Canada et al., "Meeting Canada's Obligations to Affordable Housing and Supports for People with Disabilities to Live Independently in the Community: Under Articles 19 and 28, Convention on the Rights of Persons with Disabilities And under Articles 2 and 11, International Covenant on Economic, Social and Cultural Rights"; Canada, "Housing, Infrastructure and Communities Canada - Everyone Counts 2020-2022 – Results from the Third Nationally Coordinated Point-in-Time Counts of Homelessness in Canada."
[430] Environment and Climate Change Canada, "Climate Trends and Variations Bulletin."

Housing shortages place burdens on health-care systems

Canada's housing crisis not only severely undermines individual health but also places a significant burden and expense on the health-care system. This creates a vicious cycle and tragic irony – public funds that should be invested upstream in supportive housing solutions are instead spent downstream on hospital care.

- Inadequate health access: 93 per cent of patients experiencing homelessness are admitted to hospital through the emergency department – a clear indication of inadequate access to primary care for managing health needs.[431]
- Increased length of hospitalization: The average hospital stay for patients experiencing homelessness is 15.4 days compared to the national average of 8.0 days.[432]
- Higher hospitalization costs: The average cost of hospitalization for patients experiencing homelessness is $16,800, double the national average.[433]
- Inappropriate use of institutional beds: In June 2024, more than 6,100 patients occupying Ontario hospital beds were designated as requiring an alternate level of care (ALC).[434] Nearly half of these patients were awaiting long-term care placements, while many others could have been accommodated in supportive housing.

Ontario's housing crisis not only undermines individual health but also disproportionately impacts marginalized populations, increases strain on the health system, and worsens health inequities. This crisis underscores the urgent need for increased fiscal investment to address the underlying social determinants of health – particularly housing and income – to improve health outcomes and advance health equity.

Recommendation E2: Environmental determinants of health

Mitigate climate-related impacts and strengthen climate resilience and health equity by advancing a low-carbon economy, accelerating the clean energy transition, and ensuring health system preparedness.

Action items

- **Low-carbon economy:**
    - Set emissions reduction targets aligned with international commitments, aiming to reduce emissions by 40-45 per cent below 2019 levels by the year 2029 and to achieve net-zero by 2050.

[431] Canadian Institute for Health Information, "Hospital Data Sheds Light on Patients Experiencing Homelessness."
[432] Canadian Institute for Health Information.
[433] Canadian Institute for Health Information.
[434] Chamandy, "Hospital Data Shows Ontario's Hallway Health Care Problem Is Worse than Ever."

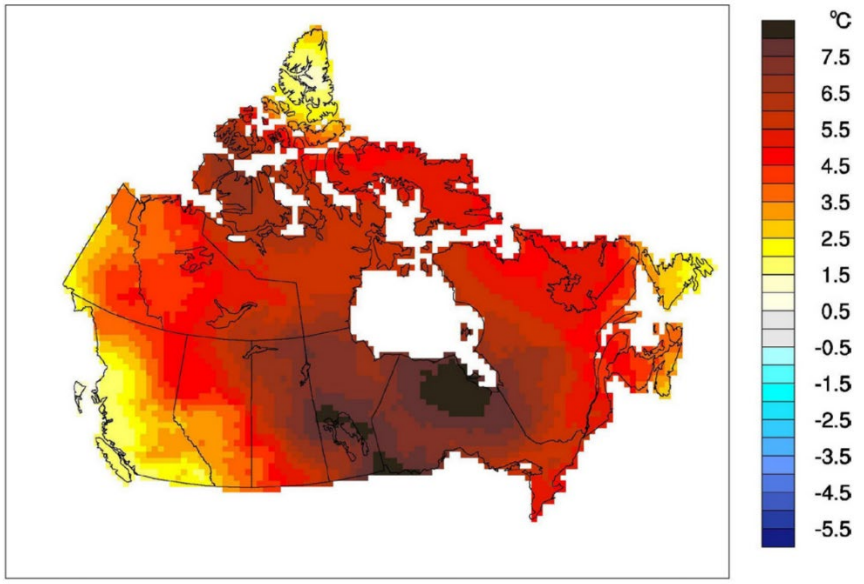
- **Phasing-out of fossil fuels:**
    - Lead a just transition to renewable and low-carbon industries, prioritizing job creation and supporting workers to train and relocate.
    - Collaborate with the federal government on carbon pricing and other national environmental policies.
- **Clean energy transition:**
    - Phase out gas-powered plants and increase investment in renewable energy rather than nuclear power.
- **Promoting liveable neighbourhoods and less dependency on cars:**
    - Enhance sustainable transportation by expanding public transit, promoting electric vehicles, and halting plans for new highway expansions.
    - Retrofit homes for energy efficiency and set stringent emission standards for new buildings, including a ban on new natural gas hookups.
- **Climate resilience:**
    - Collaborate with other jurisdictions on a national climate adaptation strategy.
    - Support municipal climate action plans and invest in climate-resilient infrastructure to address extreme weather events.
- **Health system preparedness:**
    - Mandate public health units to prepare and annually update local climate-related emergency preparedness and management plans, with a focus on vulnerable populations and required health system resources.
    - Develop climate-informed health programs and services in collaboration with all levels of government and public health to prevent and mitigate climate-related health impacts, particularly in areas such as housing, homelessness and food security.
    - Expand the health system workforce specializing in climate-related health impacts, based on local vulnerabilities and planning.
- **Indigenous Peoples:**
    - Ensure all climate mitigation and adaptation efforts uphold the rights of Indigenous peoples and comply with the United Nations Declaration on the Rights of Indigenous Peoples.

Rationale

Climate change is an immediate and growing threat to human health. We are in the midst of a climate emergency. Globally, 2024 was the second consecutive hottest year on record, with the average temperature 1.6 degrees Celsius above pre-industrial levels.

In Canada, average temperatures are rising at twice the global average – three times in the north.[435] In 2023, Canada was 2.0°C hotter than it was in 1948 – the year records commenced.[436] Last winter, was the warmest winter on record – 5.2°C above the baseline average – led largely by record highs in Ontario. Southern Ontario, defined as the Great Lakes/St. Lawrence basin, was 5.4 degrees above the baseline average, while the rest of Ontario was 6.3 degrees above the baseline average.[437]

Figure 42: Temperature departures from the 1961–1990 average, winter 2023-24[438]



Globally, human activities are driving climate change – in particular, the burning of fossil fuels, deforestation and industrial agriculture. Sustainability of life on this planet requires massive changes in energy systems and land use across the world. In the absence of dramatic change to how we live on this planet, every region around the globe will experience catastrophic climate events: heatwaves and droughts, flooding, tropical cyclones, extra-tropical storms, and increases in aridity and fire weather, at great cost to human life.

The extent to which current and future generations experience these events and their health impacts depends on the choices we make now and in the very near term. The cumulative effect of greenhouse gas (GHG) emissions means that emissions must be reduced every year to stay on the necessary path to net-zero by 2050. The fight against climate change

[435] Health Canada, "Health Impacts of Air Pollution in Canada in 2018"; Health Canada, "Wildfire Smoke and Your Health."
[436] Health Canada, "Health Impacts of Air Pollution in Canada in 2018."
[437] Health Canada.
[438] Environment and Climate Change Canada, "Climate Trends and Variations Bulletin."

demands urgent and sustained action from international, national and sub-national levels of government to mitigate a looming humanitarian catastrophe. The province of Ontario must play its part.

In 2020, the provincial government commissioned the Climate Risk Institute to perform an impact assessment of climate change on Ontario, resulting in a 505-page technical report presented in January 2023. The report paints a grim picture of historical trends in Ontario, such as rapidly declining ice cover in the Great Lakes Basin over the last half-century. In an even grimmer picture of the future, the report predicts an average of more than 60 extreme hot days (more than 30 degrees Celsius) in south-west, central and eastern Ontario later in this century.[439] The north-east and north-west of the province can anticipate more than 35 extreme hot days per year, on average. Further, the report forecasts declining productivity, crop failure, and livestock fatalities and confirms that climate risks are highest among Ontario's most vulnerable populations.[440]

Health impacts of climate change

The health impacts of climate change add to the increasing burden on Ontario's health system. Storms, freezing rain, flooding, tornadoes, wildfires and other manifestations of climate change lead to morbidity and mortality through both immediate injury, disruptions of health care delivery, evacuation, and chronic disease. For example:

Wildfires and climate-induced smog can cause immediate health outcomes, including cough, wheezing, asthma attacks, shortness of breath, nose, throat, eye and sinus irritation, dizziness, heart palpitations, chest pains and they are also high-risk factors for premature death and disability.[441] Above-background air pollution contributed to 17,400 premature deaths across Canada in 2018, with more severe health impacts in densely populated or heavily polluted areas.[442] An estimated 6,500 of these deaths – more than one-third of the national premature death toll – happened in Ontario.[443]

Heat waves and extended heat exposure affect health in multiple ways. Extreme heat can cause heat exhaustion, heat illness, heat stroke and even death,[444] and also worsens pre-

[439] Climate Risk Institute et al., "Ontario Provincial Climate Change Impact Assessment Technical Report - January 2023."
[440] Climate Risk Institute et al.
[441] Environment and Climate Change Canada, "Temperature Change in Canada."
[442] Environment and Climate Change Canada.
[443] Environment and Climate Change Canada.
[444] Health Canada, "Wildfire Smoke and Your Health"; Canadian Medical Association, "Insight."

existing conditions such as kidney issues.[445] Extreme heat also increases mental health distress, including anxiety, depression, agitation, violence and suicide attempt.[446]

Flooding can result in drowning, acute trauma and physical injuries from direct contact with flood water.[447] Other health risks related to flooding include shock, hypothermia, exertion and stress related conditions, such as high blood pressure, heart attacks and strokes.[448] Flooding can also spread waterborne diseases and increase exposure to mould, fungi and bacteria, which can in turn lead to skin rashes, allergies, asthma, and eye and ear infections.[449]

Warming temperatures are also responsible for the increase in vector-borne disease in Ontario. The incidence of Lyme disease, for example, has increased at a phenomenal rate in Ontario. Bites from infected ticks result in skin rash, fever, headaches, fatigue, muscle and joint pain and delayed treatment may lead to serious long-term symptoms including heart problems, immune system, endocrine system, neurological system problems and even death.

Mental health impacts also result from both the looming threat and the actual manifestations of climate change. Increasingly frequent events such as flooding, wildfires, and heatwaves give rise to significant psychological stress, contributing to what is now recognized as "eco-anxiety" – a chronic fear of environmental doom linked to the anticipated consequences of climate change. Eco-anxiety can manifest as feelings of helplessness, grief, anger, and despair, particularly among those who feel powerless to influence the global response to the crisis. Inadequately housed and economically disadvantaged groups are especially vulnerable, as they face disproportionate exposure to climate-related disasters while having fewer resources to cope. Young people, in particular, experience heightened eco-anxiety as they grapple with the knowledge that the climate crisis threatens their futures, their livelihoods, and the natural world they depend on. Left unaddressed, these mental health impacts have the potential to strain health systems and worsen existing inequities.[450]

Adding to the damaging health impacts of climate change is the erosion of the social and economic conditions that support health. The 2023 impact assessment report highlights the

[445] Canadian Medical Association, "Insight."
[446] Canadian Medical Association; Howard, "Climate Change and Gender – Learn the Intersectional Impacts."
[447] Canadian Climate Institute, "Fact Sheet: Climate Change and Floods."
[448] Canadian Climate Institute.
[449] Canadian Climate Institute.
[450] Clayton, "Climate Anxiety."

effects of climate change on the determinants of health – including economic security, food and water security, and natural systems and species.

Health equity in the context of climate change

Climate change imposes disproportionate health impacts on marginalized populations. Increased environmental instability often intersects with socio-economic determinants such as poverty, food insecurity and barriers to health-care access. This compounds health risks and deepens health inequities.

For example, Indigenous communities experience disproportionate health impacts from climate change due to their deep, intrinsic connection to the natural environment. Disruptions to these systems affect every aspect of life – from food security to physical and mental health, spirituality and cultural identity.[451]

People experiencing homelessness and those in core housing need face greater risks from extreme heat, cold and precipitation. Environmental stressors such as heat waves, flooding, wildfires, and air pollution compound existing social inequities, creating cumulative negative health impacts. These inequitable outcomes highlight the urgent need to prioritize infrastructure improvements and targeted supports for marginalized populations, as recommended in the 2023 Ontario government impact assessment report. The health system must also adapt to address local vulnerabilities and health resource needs.

Summary of recommendation

Ontario's 2023 climate impact assessment report offers a damning critique of the provincial government's failure to act on climate change: "Ontario has already been affected by climate change as evidenced by recent events such as flooding, heat waves, and unusually high climate variability or extremes. The impacts of climate change have the potential to affect built and natural systems through water shortages, forest fires, power outages, outbreaks of diseases, and more. These changes in climate translate into risks to economic sectors, ecosystems, communities, and people. Ontario, in general, has high institutional, technical, human and financial levels of capacity to support adaptation actions, however, this capacity has not yet been mobilized widely despite the imperative."[452]

This is a stark reminder that we are hurtling toward a dangerous and deadly future – not by accident, but by policy choice. As the report states: "Incorporating climate change resilience

[451] Berry, Schnitter, and Noor, "Climate Change and Health Linkages."
[452] Climate Risk Institute et al., "Ontario Provincial Climate Change Impact Assessment Technical Report - January 2023."

into decision-making requires the right information, tools, resources and most importantly, willingness".[453]

Ontario must urgently revise its climate change policy. The health of Ontarians – and the sustainability of our health system – depends on it.

[453] Climate Risk Institute et al.

Appendices

Appendix A: Elements of an integrated home-care model

Integrated home care can be supported by[454]:

- Updating the outdated funding model for home and community care services.
- Providing home and community care directly through Ontario Health Teams and health service providers.
- Facilitating sectoral integration and access to home and community care services by embedding RN-led system navigation in primary care.
- Implementing contract and funding models for home and community care that promote and ensure accountability for quality, person-centred care.
- Ensuring that any dollars saved from increased integration, care coordination and better outcomes are re-invested into additional access to home care services for Ontarians and not to profit-making.
- Introducing more 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.[455]
- Strengthening accountability for service provider organizations by enacting clear policies, performance metrics reporting, and auditing. This must also include public reporting requirements.[456]

[454] RNAO, "RNAO's Response to Bill 175: Submission to the Standing Committee on the Legislative Assembly"; RNAO, "Submission to the Ministry of Health on Bill 135, Convenient Care at Home Act, 2023"; RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians"; RNAO, "Submission Re Proposed New Regulation under the Connecting Care Act, 2019."; RNAO, "RNAO's Response to Bill 175: Submission to the Standing Committee on the Legislative Assembly"; RNAO, "Submission to the Ministry of Health on Bill 135, Convenient Care at Home Act, 2023," 135; RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians"; RNAO, "Submission Re Proposed New Regulation under the Connecting Care Act, 2019."

[455] Enguidanos, Gibbs, and Jamison, "From Hospital to Home"; Lewandowski and Adamle, "Substantive Areas of Clinical Nurse Specialist Practice"; Murtaugh et al., "Just-in-Time Evidence-Based e-Mail 'Reminders' in Home Health Care"; Ornstein et al., "To the Hospital and Back Home Again"; Parab et al., "Specialist Home-Based Nursing Services for Children with Acute and Chronic Illnesses"; RNAO, "ECCO Model 3.0: Enhancing Community Care for Ontarians."

[456] SE Health et al., "How to Bring Health Home & Stabilize Ontario's Health Care System."

Appendix B: Functions of care coordinators in primary care

The role of the care coordinator in primary care must include the following:

- 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 coordinated 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 atHome, which leads the placement system (e.g., waitlists and vacancies).
- Assessing and monitoring health status and wellbeing, with ongoing evaluation of effectiveness of interventions.

Appendix C: Funding to promote the Quintuple Aim – The evidence

The following is a technical presentation of *Recommendation D3: Funding to promote the Quintuple Aim* (see page 117):

Recommendation

Ontario's health system should fund Ontario Health Teams in ways that advance the Quintuple Aim:

- Improving the patient experience.
- Enhancing patient and population health outcomes.
- Controlling costs.
- Supporting better provider experiences.
- Promoting health equity (fair access and outcomes for everyone).

Action items

- Establish measurement of "attributed populations" (the population that a given OHT is responsible for) with a focus on equity.
- Ensure risk adjustors reflect equity, ample population heterogeneity and fair pricing,
- Ensure precision while defining bundles for comprehensive care,
- Consider pooled funding to better integrate health care and social services,
- Use a double-sided shared-savings approach to foster accountability across the OHT spectrum.
- Incentivize providers to join OHTs.
- Make incremental and collaborative changes to provider payment methods.

Rationale

Establish attributed population measurement with a focus on equity.

OHT's funding model relies heavily on the count of "attributed population" (the population that the OHT is responsible for and on which outcomes and costs will be calculated). Ensuring a verified count of the population is needed to estimate and optimize adequate funding.[457] The Ministry has instructed all OHTs to ensure equity in health and care access,

[457] World Health Organization, "Formula Funding of Health Services: Learning from Experience in Some Developed Countries."

experience and outcomes across diverse communities, people with disabilities, refugees and people experiencing homelessness.[458]

The Ministry's current criteria for measuring attributed populations automatically excludes people who have not sought primary care services within the previous three-year window, those with no designated postal codes, and those who do not have regular primary care providers. So, for example, newcomers to Canada or people experiencing homelessness could easily be left out of the count.[459] (See also *Recommendation E1: Fiscal effort and social determinants of health*, page 121.)

With the October 2024 appointment of Dr. Jane Philpott as chair of the province's new Primary Action Care Team, RNAO anticipates a change in the attributed population methodology to assign every household in Ontario to a primary care clinic based on their home base regardless of where they move.[460] (See also Recommendation A2a: *Universal reach of primary care*, page 57.) Other important considerations: patient proximity to the care providers within an OHT; existing referral patterns; the care needs of the population; and the specific mix of providers within an Ontario Health Team.[461]

Ensure risk adjustment reflect equity and ample population heterogeneity.

Including risk-adjusted integrated population-based funding into the funding formula ensures fairer pricing and minimizes the possibility of "cream skimming" (that is, the practice of only selecting lower-risk or less complex patients who would be expected to have costs below the payment rate). Integrated funding typically includes adjusting for age and sex.[462] To better predict actual health-care spending, OHTs must incorporate socioeconomic, clinical and epidemiological indicators into their funding formulas. Formulas that adjust only for age and sex metrics are insufficient; health-care costs are highly dependent on an individual's race, immigration status, and/or health-care conditions.[463]

Developing standardized race/ethnicity measurements across health systems is considered a starting point for moving toward health equity.[464] Evidence shows that countries with integrated health systems often consider race/ethnicity, multiple socioeconomic measures

[458] Ontario Health, "OHT FY 24/25 Agreement: OHT Operating Plan Guidance."
[459] Ontario Health, "Ontario Health Teams: Data Supports Guidance Document."
[460] Philpott, *Health for All*.
[461] Ontario Ministry of Health, "Ontario Health Teams: Guidance for Health Care Providers and Organizations."
[462] Hildebrandt et al., "Gesundes Kinzigtal Integrated Care"; Penno, Gauld, and Audas, "How Are Population-Based Funding Formulae for Healthcare Composed?"; NHS England, "Technical Guide to Allocation Formulae and Convergence"; van Kleef, van Vliet, and Oskam, "Risk Adjustment in Health Insurance Markets."
[463] Cram, Lu, and Li, "Bundled Payments for Elective Primary Total Knee Arthroplasty"; Leatt, Pink, and Guerriere, "Towards a Canadian Model of Integrated Healthcare."
[464] Williams, Walker, and Egede, "Achieving Equity in an Evolving Healthcare System."

(e.g., source of income, housing composition, level of education, homelessness, housing tenure), clinical and epidemiological factors (e.g., multiple-year high-cost groups, standardized mortality rates, long term illness rates, and previous diagnoses) as health predictors.[465]

Ensure precision while defining bundles for comprehensive care.

Bundled payment – activity-based funding tied to addressing specific episodic health conditions – operates in tandem with risk-adjusted capitation funding. The Ministry currently focuses on five "integrated clinical pathways": congestive heart failure, chronic obstructive pulmonary disease, lower limb preservation, mental health and addictions, and palliative care.[466] OHTs are recommended to focus on "at least two target populations" with efforts to expand reach and impact for these populations and consider expanding to additional target populations.[467]

Comprehensive care is the goal of bundled payments. With an integrated health system, it can be challenging to decide which services should be bundled. Incomplete or fragmented bundles can reinforce fragmented care for patients with co-occurring conditions and influence health-care spending by shifting costs outside the care bundle.[468] They also influence collaboration among interprofessional care providers across sectors, becoming especially tricky for longer-term bundles with specific chronic conditions when all related care and ongoing patient costs need to be bundled in one payment.[469] In a context where bundled payments are offered alongside other funding models, it is also paramount to track total system costs accurately as a safeguard against "gaming" – picking the lower-cost option at the possible expense of patients.[470]

[465] Hildebrandt. et al., "Gesundes Kinzigtal Integrated Care"; Penno, Gauld, and Audas, "How Are Population-Based Funding Formulae for Healthcare Composed?"; NHS England, "Technical Guide to Allocation Formulae and Convergence"; van Kleef, van Vliet, and Oskam, "Risk Adjustment in Health Insurance Markets."
[466] Ontario Health, "OHT FY 24/25 Agreement: OHT Operating Plan Guidance."
[467] Ontario Health; Ontario Ministry of Health, "Ontario Health Teams: Guidance for Health Care Providers and Organizations."
[468] Bour et al., "How Can a Bundled Payment Model Incentivize the Transition from Single-Disease Management to Person-Centred and Integrated Care for Chronic Diseases in the Netherlands?"; Jacobs et al., "Bundling Care and Payment: Evidence From Early-Adopters."
[469] Bour et al., "How Can a Bundled Payment Model Incentivize the Transition from Single-Disease Management to Person-Centred and Integrated Care for Chronic Diseases in the Netherlands?"; Jacobs et al., "Bundling Care and Payment: Evidence From Early-Adopters."
[470] Jacobs et al., "Bundling Care and Payment: Evidence From Early-Adopters."

Consider pooled funding to integrate health care and social services better.

In Ontario, services that address social determinants of health in Ontario are co-funded by provincial and municipal governments and governed at the municipal level.[471] Even though some OHTs have municipal engagement and municipal representation in their boards and communities, this poses challenges related to jurisdictional issues including separate budgets.[472] The separation of health and social service budgets provides a perverse incentive for providers to maximize profits and work against integration.[473] Evidence shows that other integrated health systems have considered pooled funding across health care and social services to meet agreed upon objectives.[474] In order for this type of integration to succeed, all parties involved must have access to the same information and a single governance structure must be in place.[475]

Foster accountability across the OHT spectrum using a double-sided shared-savings approach.

Integrated funding often ties with a double-sided shared-savings approach[476] to balance the tension between efficiency and access, protect providers from extraordinary expenses, and incentivize risk-averse for-profit entities to collaborate in a non-profit environment through certainty. The Ministry has already envisioned incorporating a shared savings incentive structure into their funding model, allowing OHTs and their participating partners to share financial gains from realized savings after meeting minimum quality and performance targets.[477] OHTs are presently instructed to reinvest all savings into frontline care, including funding additional services, quality improvement interventions and so on.[478] One way to ensure distribution of savings across all OHT sector partners: Distribute some of the realized savings across the participating sector partners and keep the remaining amount to improve overall OHT activities related to frontline care. Should there be losses, those would be

[471] Bhuiya et al., "Examining the Intersections between Ontario Health Teams and Broader Human Services."
[472] Cummins, "OHT Update Association of Municipalities of Ontario"
[473] Mason et al., "Integrating Funds for Health and Social Care."
[474] Bäck and Calltorp, "The Norrtaelje Model"; Gongora-Salazar et al., "Commissioning [Integrated] Care in England"; van Vooren et al., "Transforming towards Sustainable Health and Wellbeing Systems."
[475] Mason et al., "Integrating Funds for Health and Social Care"; Sandhu et al., "Integrated Health and Social Care in the United States."
[476] Providers use double-sided sharing approached to share a percentage of any net savings realized; they would also be responsible for a percentage of any costs that exceed the budgeted amount. Under this approach, organizations and providers share the risk of relative success or failure (Scott et al., 2016).
[477] Ontario Ministry of Health, "Ontario Health Teams: Guidance for Health Care Providers and Organizations."
[478] Ontario Ministry of Health.

distributed among partners as well; this approach would foster mutual accountability and provide an incentive for all OHT partners to work towards efficiency within their sectors.[479]

Incentivize providers to join OHTs.

To achieve OHT priorities, broader engagement of health-care and social service providers is essential. However, with physician participation in OHTs remaining voluntary, and given physicians and health-care organizations can be members of a single OHT.[480] attracting qualified providers poses a significant challenge. This challenge is further compounded by the government's recent mandate to grant private for-profit clinics permanent autonomy to perform publicly funded surgeries and diagnostic procedures. To address these concerns, OHTs must offer strong incentives to attract and retain qualified health care providers. These incentives may take the form of direct participation payments or be structured based on factors such as the health risk profile of enrolled residents, the scope of required care, and the progress made in preventive care or chronic disease management.[481]

Ensure any changes to provider payment methods be made incrementally and collaboratively.

Changing provider payment methods is one tool that can be used to advance and promote integrated care delivery.[482] Although the Ministry posits that "successful Ontario Health Teams can be built on existing physician remuneration models,"[483] the reality is that current physician payment methods in Ontario mostly operate in silos due to differences in practice models and health-care settings. They may also provide disincentives for physicians to engage fully in the community aspects of OHT work[484] – meaning that any changes should be incremental.

A more holistic provider payment method would pay the interprofessional team across sectors through a mixed-payment method consisting of three components: combination of capitation and fee-for-services, bundled payments for multidisciplinary care, and

[479] Bour et al., "How Can a Bundled Payment Model Incentivize the Transition from Single-Disease Management to Person-Centred and Integrated Care for Chronic Diseases in the Netherlands?"; McDaid et al., "Incentivising Integrated Care"; Jacobs et al., "Bundling Care and Payment: Evidence From Early-Adopters"; Scott, Tjosvold, and Chojecki, "Gainsharing and Shared Savings Strategies in the Healthcare Setting: Evidence for Effectiveness"; Pines et al., "Kaiser Permanente – California: A Model for Integrated Care for the Ill and Injured."
[480] Ontario Health, "Ontario Health Team: Full Application."
[481] McDaid et al., "Incentivising Integrated Care"; NHS finance, "HFMA Introductory Guide Updated February 2025"; Ministry of Health Singapore, "The White Paper on Healthier SG."
[482] Korda and Eldridge, "Payment Incentives and Integrated Care Delivery."
[483] Ontario Ministry of Health, "Ontario Health Teams: Guidance for Health Care Providers and Organizations."
[484] For example, an early evaluation of 12 OHTs reported that primary care physicians involved in the OHT planning process (non-clinical duties) were paid less than they would have made performing purely clinical duties (Embuldeniya et al., 2021).

incentives.[485] One opportunity for incremental change: incorporate the incentives for social care into physician compensation through a "pay-for-coordination" approach.[486] It is crucial because primary care physicians are the first point of contact to access social services and this incentive is needed to compensate for the additional workload related to task-shifting across sectors.[487]

Pay-for-performance has been considered as one of the components of provider payment in several integrated systems.[488] However, one randomized trial found that compared to the control group, the performance of incentivized professionals was not sustained after the incentive intervention had ended.[489] Besides, this payment mechanism can be challenging for providers with an extensive number of clinical targets or patients with multimorbidity.[490] Evidence shows that pay-for-performance introduces a risk for gaming behaviour, with the size of that risk contingent upon the proportion of a provider's income that comes from the quality-payment.[491]

[485] Abualbishr Alshreef, "Provider Payment Mechanisms: Effective Policy Tools for Achieving Universal and Sustainable Healthcare Coverage"; Bour et al., "How Can a Bundled Payment Model Incentivize the Transition from Single-Disease Management to Person-Centred and Integrated Care for Chronic Diseases in the Netherlands?"; Jia et al., "Payment Methods for Healthcare Providers Working in Outpatient Healthcare Settings"; Langenbrunner, Cashin, and O'Dougherty, "Designing and Implementing Health Care Provider Payment Systems How-To Manuals"; Tan et al., "Primary Care Governance and Financing: Models and Approaches."

[486] Sandhu et al., "Integrated Health and Social Care in the United States."

[487] Abualbishr Alshreef, "Provider Payment Mechanisms: Effective Policy Tools for Achieving Universal and Sustainable Healthcare Coverage; Bour et al., "How Can a Bundled Payment Model Incentivize the Transition from Single-Disease Management to Person-Centred and Integrated Care for Chronic Diseases in the Netherlands?"; Jia et al., "Payment Methods for Healthcare Providers Working in Outpatient Healthcare Settings"; Langenbrunner, Cashin, and O'Dougherty, "Designing and Implementing Health Care Provider Payment Systems How-To Manuals"; Tan et al., "Primary Care Governance and Financing: Models and Approaches"; Tsiachristas, "Financial Incentives to Stimulate Integration of Care."

[488] Jia et al., "Payment Methods for Healthcare Providers Working in Outpatient Healthcare Settings"; Tan et al., "Primary Care Governance and Financing: Models and Approaches"; Varkevisser et al., *Sustainability and Resilience in the Dutch Health System*.

[489] Tan et al., "Primary Care Governance and Financing: Models and Approaches."

[490] Roland and Olesen, "Can Pay for Performance Improve the Quality of Primary Care?"

[491] Korda and Eldridge, "Payment Incentives and Integrated Care Delivery"; Rosenthal and Frank, "What Is the Empirical Basis for Paying for Quality in Health Care?"

Appendix D: ECCO model: Health system transformation progress chart

ECCO 1.0	ECCO 2.0	ECCO 3.0	Progress to date	ECCO 4.0 (next steps)
Population health				
• Need an upstream approach to care based on health promotion, disease prevention and early intervention to prevent costly complications. • Leverage the expertise of public health to inspire community engagement and population health planning.	• Leverage the expertise of public health to inspire community engagement and population health planning.	• Leverage the expertise of public health to inspire community engagement and population health planning. • Design and deliver population health programs that advance health equity.	• The Ontario Health Teams Patient, Family and Caregiver Partnership and Engagement Strategy: Guidance Document established a framework for OHTs to incorporate patients, families, caregivers and communities in delivering person-centred care, with a strong focus on health equity by addressing the unique needs of vulnerable populations, including Indigenous, Black, or other racialized, and/or Francophone patients, families or caregivers. • At maturity, all OHTs are expected to engage patients and communities in delivering person-centred care and advance population health by addressing the	• Incorporate person-centred care across the health system, focusing on powering people, continuity of care, and shared decision-making. • Include community representation from the OHT's attributed population on the board of the coordinating corporation. • Encourage community participation and power communities to actively engage in the planning and decision-making processes of health policies and services. • Ensure health and social services are tailored to meet the unique needs of the attributed population.

			determinants of health.	
Public health				
• Encourage community participation and power communities to actively engage in the planning and decision-making processes of health policies and services • Public health nurses will work closely with primary care RN co-ordinators to support integration between primary care and public health. • Public Health Units will continue to play a critical role in supporting health promotion, disease prevention and community mobilization/development • 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.	• Public Health Units must remain as intact entities with a goal of advancing primary health-care across the health system. • Public health nurses will support integration between primary care and public health • Leverage the significant expertise of Public Health Units in the areas of addressing the social determinants of health and community engagement and consultation.	• Engage public health as an active partner in health-system transformation. • Align independent public health entities with the integrated health system, while increasing the overall funding to public health. • 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.	• The Ontario government has emphasized the need for OHTs to identify target populations and advance improvements for clinical priorities including chronic disease, mental health and addictions and palliative care. • Some OHTs have already begun the process of population segmentation for needs, risks and barriers, which exemplifies identifying target population.	• Support public health to reach its full capacity and potential. • Recognize and leverage public health expertise and resources to inspire and inform population health planning, management, and accountability. • Include public health as a mandatory member of all boards of OHT coordinating corporations. • Improve system integration and efficiency by fostering collaboration between primary care and public health sectors.
Primary care				
• Advance primary health care for all by expanding the reach, functions and access to comprehensive interprofessional primary care models, integrating social and	• Advance primary health care for all by expanding the reach, functions and access to comprehensive interprofessional primary care models, integrating social	• Expand the reach of and access to primary care to ensure all Ontarians are linked with a primary care team. • Build relationships	• Primary care teams connected to OHTs are encouraged to partner with community groups to co-design and implement	• Ensure that everyone is attached to a family doctor or nurse practitioner (NP) and has 24/7 access to urgent, non-emergency care.

environmental determinants of health. • Support the local organization of primary care, by establishing local primary care networks. • The ECCO model places a moratorium on the creation of new solo practice models in primary care. • Transition solo physicians into group-based models of primary care delivery, as a step towards exclusive interprofessional primary care delivery. • Strengthen and expand interprofessional primary care delivery models.	and environmental determinants of health. • Support the local organization of primary care, by establishing local primary care networks. It is expected that these networks will provide after-hours service – including overnight – through rotating coverage by interprofessional primary care providers. • Place a moratorium on the creation of new solo practice models in primary care, and transition solo physicians into group-based models of primary care delivery. • Strengthen and expand interprofessional primary care delivery models.	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. • Fund primary care models based on the implementation of a primary health-care approach, inclusive of upstream social and environmental determinants of health. • 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	integrated programs and services for marginalized populations, including Indigenous, racialized, Francophone and 2SLGBTQI+ groups. • On Feb. 1, 2024, Ontario announced an investment of $110 million in 2024–25, to connect up to 328,000 people to a primary care provider. • In Ontario's 2024 budget, the government pledged a total investment of $546 million over three years, starting in 2024–25, aiming to connect 600,000 people to team-based primary care through new and expanded interprofessional care teams. • In October 2024, Dr. Jane Philpott was appointed by the Ontario government to lead a new primary care action team with a mandate to connect every person in	• Ensure all primary care is provided through an interprofessional team-based model. • Implement a strategy to grow the pool of primary care providers. • Expand the number of NP-led clinics across Ontario. • Prioritize community-based primary models that have proven effective at increasing access and equity for disadvantaged populations, including nurse practitioner-led clinics (NPLC), community health centres, Indigenous Primary Health Care Organizations and Aboriginal Health Access Centres. • Ensure access to primary care services for everyone, without discrimination or differential treatment. • Address barriers to primary care and the impacts of health determinants through community outreach, EDI

		practice models of primary care. • Connect all existing primary care providers to interprofessional teams.	Ontario to primary health care within the next five years. • In January 2025, the Ontario government announced $1.4 billion in new funding "to connect two million more people to a publicly funded family doctor or primary care team within four years". • Ontario's Primary Care Action Plan was also released in January 2025, with the commitment of creating and expanding 305 additional teams to attach approximately two million people to primary care.	planning tools, social interventions, and equity-oriented health care.
Care coordination/ navigation				
• Primary care RNs must take a lead role in the care co-ordination and system navigation process. • The ECCO model proposes transitioning the approximately 3,500 case managers/care co-ordinators currently employed within CCACs into interprofessional	• Coordinate care within primary care. • Primary care RNs must take a lead role in the care co-ordination and system navigation process. • Transition CCAC Care coordinators to primary care to anchor the health system in primary care, while eliminating	• 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 atHome was created through the passage of Bill 135. Its objectives include the provision of operational supports, including care coordination services, to health service providers and OHTs.	• Make comprehensive care coordination, based in primary care, available to all Ontarians. • Transfer care coordinators working for Ontario Health atHome to primary care and other community-based organizations to

primary care models.	duplication, inefficiency and maximizing current infrastructure, health-care expenditures, and roles.	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, and determine appropriate care load.	• In 2019, a government guidance document for OHTs stated "Each OHT is to offer patients 24/7 access to coordination of care and system navigation services". • However, the Ministry's latest 2024 OHT Operating Plan Guidance document states that the expectation for 24/7 navigation has been removed. • OHTs are now charged with ensuring that "Ontarians know who to contact to find and access the services they need," and ensuring that "health or community services providers within an individual's circle of care are aware of how to navigate patients to available services"	work in care coordinator roles. • Expand the care coordinator role to provide comprehensive and consistent service for all Ontarians. • Situate RN care coordinators and navigators in primary care to facilitate system navigation, including the provision of referrals for home care services.

Home care				
• Home health-care and community support services must be increased and must become more robust. • Service contracts should be awarded through a non-competitive process that favours results-based quality. • Home health-care providers must be required to offer a range of accessible services that promote continuity and avoid fragmented care across different agencies. • Outcome-based funding must flow in baskets, based on best practices, directly from the LHIN to the home health-care organization.	• The ECCO model envisions home health-care services becoming more robust and increasing. • Service contracts must be awarded by the LHIN through a non-competitive process that favours results-based quality. • The funding model must be reformed from a per-visit basis to funding baskets that follow evidence-based pathways.	• Ensure robust home and community care services. • Transition the responsibility for home-care services directly to home-care agencies. • 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. • Reform the home-care funding model from a per-visit basis to funding baskets to that allow a person-centred approach.	• The province's 14 regional Home and Community Care Support Services organizations were consolidated to create a single integrated service organization – Ontario Health atHome. • Ontario Health atHome care coordinators will eventually be assigned to work within OHTs and other frontline care settings to support care transitions. • The Ministry has engaged in a process to update the home care procurement and contracting process, with a focus on introducing new performance standards, updating standardized contracts and protecting current service volumes. • An initial group of 12 OHTs were selected to accelerate their work to deliver	• 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. • Increase home care funding to support an expanded publicly-funded basket of home and community services. • Scale and support models of home care within OHTs that

			home care starting in 2025, which will include supporting care transitions between primary care, hospital, and home and community care. • The government has announced home care investments of $548.5 million in 2021, an additional $1 billion in 2022, and an additional $2 billion in 2024.	facilitate integration between home care and other sectors.
Long-term care				
• Within the ECCO model, the role of long-term care (LTC) homes is to care for residents who, despite all efforts, are unable to receive care within the community. • LTC home administrators will work closely with the primary care RN co-ordinator, the client, the family and the LHIN to ensure that an effective and timely placement system is implemented.	• The ECCO model proposes a fundamental shift from a task-focus to a resident focus, while simultaneously shifting from a compliance focus to a culture of quality and evidence-based practice. • Evidence-based minimum service requirements should be adopted, including funding for no less than an average of 4.0 hours of nursing care per resident, per day • Staff mix of: (1) one NP per LTC	• 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. • Incorporate a focus on the person-first philosophy. • Modernize the funding formula in LTC – immediately – to account for complexity of	• Investing up to $4.9 billion over four years to increase LTC staffing, to meet provincial direct care hours for residents by March 31, 2025. • Legislating requirements for direct hours of nursing and personal care, as well as for allied health professionals. • Amending regulations to define infection prevention and control (IPAC) lead staffing requirements for LTC homes,	• Require that all OHTs incorporate LTC as part of their team configuration to ensure that all LTC facilities are actively connected to the full health system. • Incorporate a focus on person-centred care by collecting sociodemographic data, expanding ethnocultural homes, and providing culturally safe care. • Improve quality of care in LTC homes by changing the

	Home, with no less than one NP per 120 residents, (2) at least 20 per cent RNs, (3) 25 per cent RPNs and (4) 55 per cent personal support workers (PSWs), subject to increases that align with greater acuity.	care needs and quality outcomes. • Modernize staffing in nursing homes immediately. • Develop new and renovated nursing homes for persons with dementia.	and providing related funding. • Providing funding to support LTC placements for nursing and personal support work (PSW) students. • Announcing funding to hire 225 nurse practitioner (NP) positions in Ontario LTC homes. • Strengthening inspections processes in LTC. • Introducing funding for clinical decision support tools in LTC such as RNAO Clinical Pathways™. • Enabling specialized supports to help LTC homes support residents with complex needs. • Utilizing NPs as clinical directors in LTC.	funding formula, using RNAO's LTC Best Practices Program, mandating all long-term care homes to report on key indicators, and supporting development of non-profit homes. • Modernize staffing in nursing homes by implementing RNAO's Nursing Home Basic Care Guarantee. • Develop new and renovated nursing homes for persons with dementia.
Digital health				
• n/a	• n/a	• Optimize digital health technologies to improve access, enhance integration and support person-centred care. • Establish a standardized and shared system for	• The Ontario government has undertaken initiatives to improve digital health and interoperability within the province, including a "digital health	• Establish a standardized and shared system for collecting data and disseminating population health information across the system.

		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.	playbook", a guidance document regarding the Ontario Health Teams Harmonized Information Management Plan, the *Ontario Health Data Council Report*, and relevant policies and regulations. • In its most recent OHT operating plan guidance document, the government has also asked OHTs to: ○ collect/report data on key performance metrics. ○ integrate a digital, data, and analytics plan focused on supporting clinical priorities within their overall OHT plan. ○ implement the provincial "Patients Before Paperwork Strategy" to relieve administrative burden and eliminate the use of fax technology. ○ identify digital solutions within the OHT and	• Develop and maintain a province-wide strategy to make electronic personal health records available to all Ontarians. • Enhance the content of the province's electronic health record with robust information from primary and community care settings, to establish complete and accessible longitudinal patient records. • Facilitate interconnections between primary care, specialty care, community care, and patients/ families/ caregivers to improve collaborative integrated care and promote safe care transitions. • Actively involve and engage nurses and health providers in the procurement, adaptation, adoption and implementation of digital health technologies when used in clinical practice. • Require all organizations to

			provide updates about uptake and lessons learned.	implement policies related to digital health technologies to protect privacy, security and confidentiality. • Require OHTs to: ○ collect/report data on key performance metrics and analyze the data to plan and mobilize resources. ○ implement digital health solutions.
Evidence-based practice				
• Improve quality of care and outcomes across the health-care continuum by expecting and supporting evidence-based care.	• Improve quality of care and outcomes across the health-care continuum by expecting and supporting evidence-based care.	• 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	• OHTs will be required to implement the following interventions to promote evidence-based care: • Expanding the number of patients impacted by OHT-led clinical improvements within and across target populations, using an equity-based approach. • Reporting on the number of patients benefitting from local clinical improvements. • Reporting on locally defined OHT performance	• Demonstrate a commitment to evidence-based practice across the health system. • Nurture an evidence-based culture within OHTs. • Use RNAO BPGs to inform care delivery. • Enable integrated and person-centred care through the use of RNAO BPGs. • Encourage OHTs to participate in RNAO's BPSO OHT model. • Monitor and evaluate the impact of the implementation of evidence-based practice. • Reinvest all savings from improved

		outcomes in direct care.	monitoring indicators. • Advancing clinical improvements for at least two target populations, with efforts to expand to additional target populations. • Selecting from the clinical priorities outlined in *The Path Forward*, depending on local priorities. • Aligning measurement and evaluation of improvements to the Quintuple Aim Framework.	outcomes in direct care.
Scope of practice				
• Maximize and expand the scope of practice utilization of all regulated health professionals.	• Maximize and expand the scope of practice utilization of all regulated health professionals.	• 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	**RN scope expansion:** • The *Nursing Act (1991)* was amended in December 2023 to allow RNs who complete additional training to prescribe specific medications and communicate related diagnoses. • As announced in November 2024, RN scope will be expanded to	• Maximize and enable the full scope of practice of registered nurses, nurse practitioners and other regulated health professionals. • Implement legislative and regulatory changes to maximize appropriate and safe scope for RNs and NPs. • Remove organizational barriers that prevent RNs and NPs from working

		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.	allow them to certify a death when the death is expected. • The Ministry is seeking to integrate RN prescribing education into existing baccalaureate nursing programs as part of entry-level RN competences. **NP scope expansion** • Provincial (July 1, 2022) – NPs able to perform point-of-care tests, and order CT/MRI scans under the *Healing Arts Radiation Protection Act*, 1990, the *Regulated Health Professions Act*, 1991, and the *Laboratory and Specimen Collection Centre Licensing Act* • Federal (Nov. 29, 2023) – NPs authorized to prescribe and possess anabolic steroids other than testosterone under the *Controlled Drugs and*	to their full, legislated scope of practice. • Provide resources to enable RNs and NPs to enhance their individual knowledge, skill and judgment and develop competency in their full scope. • Further expand NP scope of practice. • Expand RN scope, including embedding RN prescribing in all Bachelor of Science in Nursing (BScN) curriculum.

			Substances Act, 1996. • May 3, 2024 – Midwives can access medications through an NP. Starting July 1, 2025, NPs will be able to: • Order and apply a defibrillator to provide faster care to someone in cardiac arrest. • Order and apply a cardiac pacemaker to make it faster for people to receive care if their heart isn't beating regularly. • Order and perform electrocoagulation, a process to treat skin conditions and lesions, such as skin tags, helping people get them removed sooner. • Certify a death in more circumstances, improving the end-of-life experience for families after the death of a loved one. • December 2024 – the government introduced the	

			Support for Seniors and Caregivers Act, 2024. If passed into law, this legislation will allow nurse practitioners to fulfill the medical director role alongside physicians and would rename the position to “clinical director”.	

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