RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario
Speaking out for nursing. Speaking out for health.

Registered Nurses' Association of Ontario

Submission to the Home and Community Care Review Expert Group

October 2014

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Introduction:

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses (RNs), nurse practitioners (NPs) and nursing students in all roles and sectors within Ontario. Our mandate is to foster knowledge-based nursing practice, promote quality work environments, deliver excellence in professional development, and advance healthy public policy. We promote the full participation of present and future RNs and NPs in improving health, and shaping and delivering health-care services. With this mandate in mind, we are pleased to provide this submission to the Ministry of Health and Long-Term Care's *Home and Community Care Review Expert Group*.

There is general agreement that Ontario's health system is not being optimized in its present form. Although planners may have had the best intentions, too much emphasis has been placed on hospital care. The outcomes of these policy decisions include soaring health-care costs and sub-optimal patient outcomes. RNAO believes in the sustainability of a single-tiered publicly-funded and not-for-profit delivery system. To optimize our health system and improve its outcomes, especially in the face of a growing and aging population, we must shift the emphasis from the institutional setting to the community. Moreover, it is the view of RNAO that the future strength of Ontario's health-care system depends on how primary care is positioned. We believe that primary care must serve as the anchor of the system.

Recognizing the need for transformative change in Ontario's health-care system, RNAO developed and launched its Enhancing Community Care for Ontarians (ECCO) model.[1] The model was first introduced in 2012 and updated in 2014 with an expanded white paper that includes more operational details. From its origin, ECCO has included the contributions of stakeholders and was recognized by health policy experts as a "health-care innovation whose time has come."[2]

RNAO has chosen to apply a systems approach in responding to this consultation, as it is impossible to achieve substantial change in the community sector in isolation of broader system reform. RNAO recognizes that the panel has posed several questions to stakeholders to facilitate consultation. Our submission is an attempt to answer these questions in a comprehensive manner, however, a summary of the submission can be found in Appendix A.

Limitations of Current Health-Care System:

A key limitation of the current health-care system is that not enough emphasis is being placed on primary care. Primary care is central to a high performing health system.[3,4,5] Additionally, insufficient focus has been placed on maximizing interprofessional delivery models. Although this is changing through the introduction of Nurse Practitioner-led Clinics (NPLC), Family Health Teams (FHT) and Community Health Centres/Aboriginal Health Access Centres (CHC/AHAC), approximately 75 per cent of Ontarians receive care outside of these models and access to care continues to be an issue.[6] Additional limitations include:

1. *Inability to offer person-centred care* – care is often delivered through a provider or funding-centric lens. This creates care and funding inequities across the province. A shift is needed to place the person at the centre of care and align services and resources to their needs.

2. *Suboptimal role utilization of regulated health-care professionals* – In 2012, RNAO released *Primary Solutions for Primary Care*, which is a key report that identified the suboptimal utilization of thousands of primary care nurses in Ontario.[7] Moreover, nurses and other health-care professionals are encountering structural and/or cultural barriers preventing them from embracing their full scope of practice across the system. A shift is needed to fully utilize all of the existing health human resources within the system.

3. *Inconsistent use of relevant evidence in clinical practice*– Significant variation in how care is delivered by all health-care professionals can drive cost inefficiencies, while also failing to deliver optimal patient outcomes. Although there is increasing adoption and utilization of evidence-informed practice, more work can be done in Ontario's health-care organizations. A shift is needed to fully develop a culture of evidence within health-service delivery.

4. *Absent or ineffective care co-ordination* – The co-ordination of care is missing. This is primarily due to the absence of a consistently recognized area of the system that is tasked with offering comprehensive care co-ordination across sectors for an extended period of time (birth to death). A shift is needed to mutually recognize an area of the health-care system that can be enabled and supported to provide comprehensive care co-ordination.

5. *Community Care Access Centre (CCACs) model* – CCACs were developed in 1996 to support the delivery of home health-care and support services. At that time, the procurement of these services was obtained through managed competition, often referred to as 'competitive bidding'. High administrative costs (roughly $200M annually[8]), coupled with the elimination of competitive bidding and the introduction of Local Health Integration Networks (LHINs) begs to question what is the role of the CCAC in today's health-care environment? A shift is needed to maximize health outcomes while being conscious of the available fiscal resources.

6. *Limited ability for whole system planning and funding* – The creation of LHINs created an opportunity to integrate care across sectors. However, the LHINs have not been successful in fully achieving this due to how they have been implemented. At present, LHINs do not have planning or funding control for much of the health-care system, including: the majority of primary care, public health and home health-care organizations. This creates a significant planning vacuum that perpetuates fragmentation across the health-care system. A shift is needed to incorporate a whole system regional planning and funding mechanism.

7. *Destabilization of the community care workforce* – The predominant funding model in home health-care is fee-for-service. Variability in demand for service creates a precarious

work environment for home health-care nurses. Moreover, compensation and benefits within the entire community sector (primary care and home health-care) fall well below other sectors, creating inequities that challenge recruitment and retention efforts. A shift is needed to stabilize the funding model in home health-care to enable person-centred care and to produce workforce stability through equitable compensation and benefits.

8. *Illness focus* – The health-care system is largely illness-focused. This translates into reactive care delivery that is often patchwork. In the home health-care environment this translates into task-based delivery models that are time-limited (depending on availability of funding) and do not incorporate health promotion. A shift is needed to create a health system (as opposed to a health-care system) with emphasis on health promotion and disease prevention.

The implications of these limitations, without targeted mitigation strategies, are significant and include:

- Increased prevalence of illness, including chronic conditions and their complications
- Delayed access to care
- People 'falling through the cracks'
- Poor health outcomes
- Uncontrollable health-care costs
- System disintegration

The quick fix being floated around by some is to increase the role of the private sector in delivering home health-care.[9] These proposals shift the financial burden of delivering care to the client as consumer.[10] RNAO vigorously objects these proposals and **will not** support any of the following:

- Increased market shares to the for-profit home health-care and/or support service delivery sector
- Co-payments
- User-fees
- Income-based means testing

RNAO will actively reject any of these approaches and urges the *Home and Community Care Review Expert Group* to identify solutions that expand publicly-funded and not-for-profit service delivery accessible to Ontarians base on health-care needs - not the size of their wallets.

Opportunities for Innovation:

Many of the 'innovations' we are proposing are not new. Instead they are solutions that RNAO has been providing to government since 2012 as part of the ECCO model and are based on evidence from other jurisdictions. The *Home and Community Care Review Expert Group* should

consider that there are a number of evidence-based solutions available. We caution the use of untested approaches or processes where the evidence is unclear or negative.

a) Primary Care:

Bodenhemier et al. identify comprehensiveness and primary care-based care co-ordination as key components of a high-performing primary care setting, noting that "improving care coordination requires teams …[and] high-performing practices often include a care coordinator … whose sole responsibility is care coordination."[11] Primary care represents a key service that must be heightened to achieve primary health care for all. Primary care must take a lead role in the care co-ordination process and this is unanimously supported by all key stakeholders through a joint position statement (Appendix B).[12] Primary care's capacity to pursue this function can be enhanced by transitioning the approximately 3,500 care coordinators currently employed within CCACs into interprofessional primary care models with their salary and benefits intact. Primary-care based, RN-led care co-ordination for complex populations is well supported within the literature.[13,14,15,16,17,18] Therefore, the 3,000 RN care co-ordinators can embrace their full scope of practice to deliver expert care co-ordination and system navigation for the minority of Ontario's population that requires the bulk of health-care resources. It is important to highlight that the health-care system is not limited by this population. Rather, this population has been limited by a health-care system that was not designed to meet their unique needs. The existing 4,000 RNs currently practising in primary care[19], along with the remaining 500 CCAC care co-ordinators and other qualified primary care providers can embrace their full scope of practice to provide co-ordination services to the balance (90 per cent) of the population with varying levels of complexity across the lifespan. These individuals often experience minimal interaction with the health-care system and when care is required, it is typically for episodic illness. However, opportunities to focus on health promotion, disease prevention and the management of chronic disease should not be missed.

A moratorium needs to be placed on the creation of new solo practice models in primary care as this impedes the progression towards interprofessional primary care teams. Government and LHINs need to strengthen and expand interprofessional primary care delivery models. In the meantime, government can begin to organize primary care delivery through integration. One way of doing this is through development of a temporary networked approach that aligns different primary care models to a network based on geographical health service grouping data, such as those identified by the Institute for Clinical Evaluative Sciences (ICES).[20] This transition will increase the capacity of current solo and group practitioners to utilize a primary care co-ordinator, as the role may be shared across a network. In effect, the networks create a virtual team as an interim approach as the government continues to invest in the implementation of formal teams (CHCs, NPLCs, FHTs and AHACs).The networks can be anchored by a single primary care organization with opportunity to rotate this position. For example, an NPLC may choose to lead a network and provide connectivity with the local FHT and Family Health Organization within the area. The primary care co-ordinator can be located within the NPLC and provide outreach to these other organizations. Over time the network may shift the lead position and a transition in leadership occurs. This transition is meant to provide opportunities for leadership development and capacity building.

Primary care networks will significantly increase the capacity of the primary care sector and stimulate the delivery of comprehensive primary care, including extended service delivery hours, complete care co-ordination and initiation of home health-care and support services. It is expected that these networks will provide after-hours service -- including overnight -- through rotating coverage by interprofessional primary care providers. In the few communities where it may be difficult to establish a primary care network, given the absence of an existing interprofessional primary care model, new CHCs, NPLCs, FHTs and/or AHACs should be developed in these regions.

Another key element of improving primary care and system capacity is through the full utilization of all regulated health-care professionals. This involves maximizing current scope of practice utilization and expanding where it is needed. For example, there is a wealth of evidence solidifying the role expansion of RNs to include prescribing.[21] This evidence-base is largely informed by the United Kingdom and its benefits can be replicated within Ontario. RNAO was pleased when the Ontario government confirmed its commitment to RN prescribing in April 2014.[22] The expanded scope of RNs will enable timely access. The first step is to develop an enabling legislative/regulatory framework, followed by supportive practice standards that recognize the unique role and competencies of nurses based on the: needs of their patients/clients, location of their practice and degree of specialization. An RN in a remote community would have very different prescribing practices compared with a specialized public health nurse in an urban setting. Therefore, RNAO is urging the government to recognize these facts by avoiding restrictive prescribing lists that ultimately serve as a barrier to care.

b) Home Health-Care:

Home health-care providers must be enabled to provide front-line care delivery to Ontarians with a focus on person-centred service priorities and full scope of practice utilization. Primary care co-ordinators can make the initial referral for home care services and rely on the expertise of home health-care organizations to develop, monitor and refine a personalized care plan for the client while maintaining information sharing with primary care. Once home health-care services are discontinued, a discharge summary can be sent to the primary care co-ordinator.

LHINs should serve as funders of home health-care organizations with service contracts being awarded through a non-competitive process that focuses on quality outcomes and accountability. All home health-care providers need to undergo accreditation and a successful outcome should be a key factor for determining contract renewal. In order to ensure continuity in service provision, home health-care providers must also be required to offer a range of accessible services that promote continuity and avoid fragmented care across different organizations. These services include nursing, personal support, and rehabilitation care.

The funding model also needs to be reformed from a per-visit basis to evidence-based pathways that achieve outcomes through provider knowledge and autonomy. In addition, the funding model must be stabilized, adjusting for seasonal variations to allow a greater proportion of full-time nursing employment within the sector to promote continuity of care and continuity of care-

giver. As a result of these changes, the role of the home health-care nurse can evolve from a task-based care model to one that is more person-centred and encompasses a range of nursing interventions that include health promotion strategies.

An issue that is common to both home health-care and primary care is compensation and benefit inequity, largely with the acute care sector and CCACs. A key report has identified that significant human resource capacity is lost each year within primary care because of this issue.[23] Additional effects have long been experienced in the home health-care setting. The Ministry of Health and Long-Term Care will not be able to achieve its aim to focus care in the community unless there is a stabilized workforce. The key to this stabilization is ensuring that compensation and benefit equity exists across sectors.

c) LHINs

In early 2014, a review of the *Local Health System Integration Act* was underway by the Legislature's Standing Committee on Social Policy. The legislation currently positions the role of LHINs as: system planners at the local level, integrators to produce co-ordinated care, community engagers, evaluators to assess local system performance and effectiveness, contributors to provincial health system plans, disseminators of best practices and knowledge, and funders of health services.[24] Undoubtedly, LHINs are not presently performing to their full mandate and their role must now expand and strengthen to correspond with their legislative intent, placing greater emphasis on horizontal integration across all sectors according to population needs and community/geographical context. RNAO responded to the Standing Committee's review calling for the inclusion of home health-care organizations, all of primary care and public health units within the LHIN mandate.[25] LHINs could leverage existing infrastructure, with minimal expansion, to accommodate the administrative functions of the CCAC. This role will involve contract management and ensuring accountability across sectors. By including all sectors, LHINs will play a pivotal role in health-system planning using evidence, community engagement and local population health needs. The timing of the Standing Committee's review provides an excellent opportunity for policy makers to consider and adopt these proposed policy changes.

d) CCACs

Given the emerging context, a discussion regarding the future structure of Ontario's health-care system and the role of CCACs is inevitable. RNAO is proposing that primary care assume the care co-ordination functions currently within CCACs, including the initiation of home health-care and support service delivery. We have also proposed that LHINs extend their planning and funding functions to all sectors including primary care, home care and public health. Lastly, we have proposed a funding and care model that embraces the autonomy of the home health-care setting. Once all of the CCAC functions have been divested, RNAO feels that the CCAC structure would represent a redundancy within the system and is no longer needed. This transition cannot occur overnight and RNAO is proposing a three year plan, through ECCO, to accomplish this divestment.

e) Evidence-Informed Practice

Evidence-informed practice drives system efficiencies by promoting the best possible outcomes for patients. When health-care professionals practice within a culture of evidence, they are adopting practices which are proven to produce the most effective outcomes. Although significant strides have been made in recent years to advance evidence-informed practice, including implementation of the *Excellent Care for All Act* within the hospital sector, more work is needed. This work involves a number of stakeholders including health-care professionals, health-care organizations, LHINs, Health Quality Ontario, researchers, educators, administrators and policy-makers.

RNAO is an international leader in the advancement of evidence-based practice through its award winning International Affairs and Best Practice Guidelines (IABPG) Centre and as an accredited ICNP Research and Development Centre, and member of the International Guidelines Network. The IABPG Centre leads the development, dissemination, support for implementation and evaluation of clinical and healthy work environment best practice guidelines. The over 50 guidelines developed include those that support direct clinical care delivery across the continuum of care, and those that support the creation of optimal work environments for nurses and other health-care professionals. Each guideline is developed through a robust systematic review of the literature and is supported by a panel of experts, and broad stakeholder consultation.

A key implementation and evaluation strategy used by RNAO's IABPG Centre is the Best Practice Spotlight Organization (BPSO) program. BPSOs are health-care and academic organizations selected by RNAO through a request for proposals process to implement and evaluate the RNAO's best practice guidelines. It is a dynamic partnership that focuses on making a positive impact on patient care though evidence-based practice. There are currently 73 BPSOs representing over 350 sites around the world and the success of this initiative has been recognized widely, see: http://www.healthcouncilcanada.ca/content.php?mnu=4&mnu1=34&mnu2=20.

In 2012, the Council of the Federation, with the aim of strengthening Medicare, identified three areas of priority outlined in the working group report on health care innovation, *'From Innovation to Action'*[26]. These priority areas included: clinical practice guidelines; team-based models; and health human resource management. RNAO contributed as a leading member of the clinical practice guidelines working group, in collaboration with the Canadian Nurses Association (CNA) and the Canadian Medical Association (CMA). The report recommended the adoption of RNAO's Guideline for the *'Assessment and Management of Foot Ulcers for People With Diabetes.'* RNAO has continued to work with stakeholders across the country to provide support for implantation of this BPG based on its vast set of evidence based resources and knowledge related to implementation science. This includes partnering with CNA to provide monthly national webinars on this guideline to policy and system leaders; as well as partnering with Canadian Association for Wound Care to produce a quarterly diabetic foot journal to help aid in the national eradication of diabetic foot ulcers (Appendix C)

For relevant examples of BPSO organizations across Canada and Ontario who are benefiting patients/clients with BPG implementation please see Appendix D.

Proposed Outcomes:

The proposed outcomes of the solutions being brought forward are plenty. Key evidence-informed outcomes include:

- Decreased prevalence of illness and delay of chronic conditions and their complications
- Improved access to timely and evidence-informed care
- Effective and comprehensive care co-ordination
- Improved health outcomes
- Controlled health-care costs, including the reinvestment of nearly $200M CCAC administrative expenditures into direct hours of home health-care delivery
- System integration

The extent to which these outcomes are achieved depends on bold and visionary leadership, along with agreement of the need for health-care system transformation. Government commitment and leadership are critical and must be expressed through the Legislature of Ontario, Ministry of Health and Long-Term and Local Health Integration Networks. Secondly, health-care system stakeholders must attempt to set aside politics and view the system objectively from a person-centred perspective. Finally, the success of any transformation strategies will be based upon the degree to which primary care is embraced as the foundation of the health-care system. Efforts to make these needed improvements will be stalled unless there is a shift from an institutional and illness focus, to a community and health focus.

Recommendations:

RNAO is pleased to offer the following recommendations to the *Home and Community Care Review Expert Group*:

1) Adopt solutions that expand a single-tiered, publicly-funded and not-for-profit health-care system, including the rejection of proposals for co-payments, user-fees, income-based means testing and increased presence of for-profit delivery in home health-care.

2) Develop a health system that is rooted in primary care and places a high focus on health promotion, illness prevention, chronic disease prevention and management, and mental health.

3) Enable person-centred care through transparent and evidence-based population health planning and funding across sectors led by LHINs.

4) Ensure the *Excellent Care for All Act* applies to all sectors and health professionals, thus creating an expectation for evidence-informed care.

5) Devolve the functions of CCACs to existing areas of this health system. This includes transitioning the care co-ordination functions and workforce (with their salary and benefits intact) to primary care.

6) Remove CCAC as a structural entity following the devolution of its functions to the LHINs and to primary care.

7) Enable the primary care regulated workforce to embrace their full scope of practice, including providing comprehensive care co-ordination and RN prescribing, as well as full utilization of NPs in all primary care models and sectors.

8) Stabilize funding models within home health-care by adopting sufficiently resourced pathways that are: evidence and outcome-based, support front-line clinical autonomy and developed in consultation with home health-care providers.

8) Secure compensation and benefit equity between the acute care sector and the primary care/home health-care sectors for RNs, NPs and Registered Practical Nurses (RPNs).

Appendix A
Survey Questions

1) What are the three greatest sources of frustration for individuals in need and their families/unpaid caregivers who are receiving home and community care? What are the home and community care sector's three greatest successes? What specific change(s) could be made to address these frustrations and/or build on these successes?

The three greatest sources of frustration for individuals in need and their families/unpaid caregivers who are receiving home and community care are:

- *The inability to receive timely and person-centred care.* Care provision is provider-centric and revolves around the availability of funding provided through the CCAC. This means that home health-care clients are not always receiving the care that they need.
- *Ineffective care co-ordination.* Care is not being co-ordinated and this results in duplication, errors and omissions. Many clients are left falling through the cracks.
- *Lack of system connectivity.* Cross sector providers are not connected leading to home health-care providers not communicating with primary care and vice versa.

The three greatest successes of the home and community care sector:

- *Recognizing the need for change.* There appears to be a mounting consensus that change is needed to adequately prepare the community sector to fully embrace its role and potential. However, there are different models being proposed.
- *Competency of the home health-care workforce*. The home health-care workforce possesses a highly competent and dedicated workforce. However, this workforce is not sustainable given the current compensation and benefit inequities in place.
- *Outcome based funding baskets*. There is increasing recognition of the need to reform home health-care funding to shift away from fee-for-service reimbursement. Continued efforts are needed to adopt appropriately resourced outcome based reimbursement pathways that use evidence and provider autonomy to promote person-centred care.

The specific changes that could be made to address frustrations and build on success include:

- Transitioning from a health-care system to a health system.
- Anchoring the health system in primary care.
- Expanding the mandate of the LHIN to include system planning, service agreements, funding and oversight for all sectors, including all of primary care, home health-care and public health.
- Devolving the functions of CCACs to existing areas of the health system, including care co-ordination to primary care; and transitioning the CCAC care-coordinators to primary care.
- Eliminating the CCAC structure once this devolution has occurred.
- Providing equitable compensation and benefits for RPNs, RNs, and NPs within the community sector (home-health care and primary care) when compared to the acute care sector.

2) What are three specific changes you believe would increase the coordination and integration of services (e.g., hospital transitions, primary care, home and community care, social services) for individuals in need and their families/unpaid caregivers so that they can be active participants in planning and managing their own care and be well supported in that role?

Three specific changes that would increase co-ordination and integration of services include:

- Anchoring the health system in primary care.
- Expanding the mandate of the LHIN to include system planning, service agreements, funding and oversight for all sectors, including all of primary care, home health-care and public health.
- Devolving the functions of CCACs to existing areas of the health system, including care co-ordination to primary care. This will involve transitioning the CCAC care-coordinators to primary care to significantly improve capacity.

3) What are three specific ways that providers of home and community care could better meet the needs of individuals in need and their families/unpaid caregivers?

Three specific ways that providers of home and community care could better meet the needs of individuals in need and their families/unpaid caregivers include:

- Shifting away from a task-focused care model to one that is person-centred. This will require enhancements to the funding model.
- Ensuring that an active connection is facilitated with the client's primary care provider.
- Promote continuity of care and caregiver through increased full-time employment of the workforce and offering a broad range of services to minimize the number of agencies involved in the care plan (when appropriate). Please see Appendix E for RNAO's Position Statement on *Strengthening Client Centred Care in Home Care*.

4) Health care consumes a significant portion of the provincial budget, and these costs are growing. What innovations and new approaches to care delivery could be made to maximize the value of our investment in home and community care? Where are the greatest opportunities for impact?

Opportunities to maximize the value of our investment in home and community care include:

- Shifting the focus from illness based care to a much greater focus on health promotion, illness prevention, chronic disease prevention and management, and mental health. .
- Maintaining the integrity of Ontario's single-tired, publicly-funded and not-for-profit health-care system by avoiding user-fees, income-based means testing, co-payments and/or increased privatization in home health-care.

- Advancing evidence-informed care.
- Promoting care co-ordination and greater system connectivity.
- Reforming the funding model in home health-care to enable person-centred care by recognizing provider autonomy, evidence and client need.
- Improving health system integration by expanding the role and responsibilities of the LHIN to include whole system planning, service agreements, funding and oversight for all community sectors: primary care, home health-care and public health. This includes devolving the functions of CCACs to the LHINs and to primary care.
- Transitioning the functions of CCACs into existing areas of the health-care system will free up at least $200M in administrative expenditures that can be reinvested into front-line home health-care delivery.

Appendix B

ONTARIO PRIMARY CARE COUNCIL ROLE OF PRIMARY CARE IN CARE COORDINATION
Position on Principles of Care Coordination Leading to Seamless Transitions for Patients and Families

Background

The Ministry of Health and Long-Term Care is transforming how care is delivered to Ontarians. The Ontario Government's *Excellent Care for All Act* and the *Action Plan for Health Care* aim to enable a health system that better responds to patient needs and delivers high quality care that is both accessible and affordable. Central to achieving elements of the Action Plan for Health Care is robust and well-coordinated primary care. Primary care is an anchor for patients and families and is well positioned to support better care coordination in primary care, including system navigation across the health system and social services.

The Ontario Primary Care Council affirms effective care coordination as a dimension of quality primary care that is patient-centered and leads to effective and more seamless transitions in care between settings and among providers. Care coordination would ensure continuity of care for patients regardless of setting, including home, community, hospital, long-term care facility or their family practice, among others. The Council has identified coordination of care as an area of shared focus because of its potential for significant positive impact on patient outcomes, health care delivery, and enabling Ontario's *Action Plan for Health*.

Position Statement

The Ontario Primary Care Council (OPCC) asserts the role of primary care providers to lead care coordination and access to appropriate programs or services. **Primary care providers will work to ensure access to interprofessional care for patients and will identify a point of contact, to help patients and families navigate and access programs and services.**

Effective care coordination will lead to more seamless transitions for patients and families, reduce duplication, increase quality of care, facilitate access, and contribute to better value by reducing costs. The OPCC believes care coordination requires dedicated funding and leadership support through training and education.

Definition of Care Coordination

To facilitate the appropriate delivery of health services, care coordination is the deliberate organization of care, services and programs that involves two participants (including the person receiving services and their family). Organizing care involves the marshaling of personnel and other resources needed to carry out all require activities, and is often managed by the exchange of effective and timely information among participants responsible for different aspects of services the person requires.[1]

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[1] Definition is an adaptation of the RNAO definition from *"Enhancing Community Care for Ontarians 1.0"* (www.rnao.ca/ecco) and the Agency for Healthcare Research and Quality (US) working definition of care coordination from "*Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination)" 2007 Jun.*

Principles of Care Coordination and Desired Outcomes

The Council's focus is guided by five principles of person-centred care coordination. These principles are shared by member organizations of the Council, and generally guide many primary care transformation initiatives. Desired outcomes are identified against each principle.

Principles of Care Coordination	Desired Outcomes
1. Care coordination is a core function of primary care and a hallmark of a high-performing primary care system.	Care coordination is provided through the patient's primary care organization throughout their life span.
2. Care coordination includes communication and planning with the patient and family.	Patients are at the centre of their plan of care. Their perspectives are fully integrated in the formulation of this plan
3. Care coordination requires a population needs based approach to planning.	A comprehensive needs assessment that includes demographics, community resources, health planning data and human resources trends informs the development of the health system, primary care and care coordination
4. Care coordination will emphasize the timely and continuous delivery of high-quality, person-centred, equitable, timely and continuous services and programs that are comprehensive, evidence-informed, culturally competent and appropriate.	There is evidence that patients receive high quality care that reflects services and programs that are comprehensive, evidence-informed, culturally competent and appropriate.
5. Care coordination focuses on the provision of comprehensive services across the health and social services continuum as needed.	There is evidence that patients experience timely access to services and seamless transitions in care.
6. Care coordination is predicated on collaborative inter-professional teams working to full scope of practice.	There is evidence that patient care is optimized when all health-care professionals are working collaboratively each at their full scope of practice.

Ontario Primary Care Council members:

Association of Family Health Teams of Ontario
Association of Ontario Health Centres
Nurse Practitioners' Association of Ontario
Ontario Medical Association
Ontario Pharmacists Association
Registered Nurses' Association of Ontario
The Ontario College of Family Physicians

Appendix C
Media Release

RNAO and CAWC join forces to produce quarterly Diabetic Foot Canada Journal, helping to aid in the national eradication of diabetic foot ulcers

2013-09-18

Melissa Di Costanzo

TORONTO, September 18, 2013 – The Registered Nurses' Association of Ontario (RNAO) and the Canadian Association of Wound Care (CAWC) are proud to announce the creation of the *Diabetic Foot Canada Journal* (DFCJ), a new, online, peer-reviewed publication targeted to health-care professionals, including nurses and physicians, who treat patients with diabetic foot ulcers. Both organizations identify this area of health care as a priority that affects quality of life and health-care costs.

The new, quarterly journal provides readers with current, practical information related to the care of persons with diabetes and how to prevent and treat foot complications. It officially launched today. Articles in the first issue include: exploring the importance of the interprofessional team when caring for patients with diabetic foot ulcers; the impact and results of the addition of a bedside foot ulcer screening tool; and an overview of RNAO's newly released second edition of a best practice guideline (BPG) related to the treatment and management of patients with diabetic foot ulcers.

According to the Canadian Diabetes Association, diabetes and pre-diabetes affect more than nine million Canadians. It's estimated to cost the national health-care system almost $17 billion annually. Diabetes, if left untreated or improperly managed, can cause health complications such as nerve, eye and kidney issues. Many people with diabetes also suffer from foot problems, which, in turn, can lead to additional health concerns, and, in 25 per cent of the cases, amputation.

"This journal is an important dissemination tool to support health-care professionals in working with persons with diabetes to prevent foot complications, or hasten wound healing," says Dr. Doris Grinspun, RNAO's chief executive officer. "RNAO is thrilled to collaborate with the CAWC to enhance the care of Canadians who are living with diabetic foot issues to prevent further problems and avert amputations."

The inaugural edition of the DFCJ follows the Council of the Federation's (CoF) 2012 decision to implement RNAO's BPG on diabetic foot ulcers across the country. CoF's *Health-Care Innovation Working Group* pinpointed diabetic foot ulcers as an issue that requires more attention, and says ulcers and amputations can be prevented with education, monitoring and early treatment. CoF is comprised of Canada's premiers and territorial leaders.

RNAO was pleased to release the second edition of its *Assessment and Management of Foot Ulcers for People with Diabetes* BPG this past spring. The association's other scientifically rigorous clinical practice guideline on this topic is *Reducing Foot Complications for People with Diabetes*. To learn more about RNAO's Best Practice Guidelines program, please visit www.RNAO.ca/bpg

Peggy Ahearn, executive director of CAWC, explains that "this focus on foot care and the new journal is clearly in keeping with the overall mission of CAWC." In fact, CAWC was funded by the Public Health Agency of Canada to develop self-management tools and deliver a peer-to-peer national educational program that engaged all stakeholders – including the patient – in the management of diabetic foot disease. "We see great benefit in our partnership with RNAO to help support members of the health-care team provide care for patients with diabetes and complications resulting in foot ulcers."

The new DFCJ eJournal is just one aspect of a broad initiative called *Diabetic Foot Canada*. The project will ensure a multidisciplinary approach and use the latest technology, evidence and teams of interprofessional experts to provide education, disseminate best evidence and educational tools, and raise awareness of the importance of preventing diabetic foot complications and amputations.
To read the journal, please visit www.diabeticfootcanadajournal.ca

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses in Ontario. Since 1925, RNAO has advocated for healthy public policy, promoted excellence in nursing practice, increased nurses' contribution to shaping the health-care system, and influenced decisions that affect nurses and the public they serve. RNAO's Best Practice Guidelines program was launched in 1999, and has delivered, to date, 39 evidence-based clinical practice guidelines and 10 healthy work environment guidelines.

For more information about RNAO, visit www.RNAO.ca You can also check out our Facebook page at www.RNAO.org/facebook or follow us on Twitter at www.twitter.com/RNAO

The Canadian Association of Wound Care (CAWC) is a national, non-profit organization of health-care professionals, researchers, corporate supporters, patients and caregivers dedicated to the advancement of wound care in Canada. Using a collaborative, interdisciplinary approach, CAWC focuses on three key areas – including professional education, research and public information – to promote effective wound management and prevention.

For more information about CAWC, please visit www.CAWC.net or www.diabeticfootcanadajournal.com

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Appendix D
Relevant BPSO Organizations and BPG Implementation

Agency	Guidelines
Home Health Care	
Bayshore Home Health (national implementation)	• Assessment and Management of Pain • Client Centred Care • Oral Health: Nursing Assessment and Intervention • Prevention of Falls and Fall Injuries in the Older Adult • Supporting and Strengthening Families Through Expected and Unexpected Life Events
CBI Home Health	• Assessment and Management of Stage I to IV Pressure Ulcers • Assessment and Management of Venous Leg Ulcers • Care and Maintenance to Reduce Vascular Access Complications • Caregiving Strategies for Older Adults with Delirium, Dementia and Depression • • Establishing Therapeutic Relationships • Ostomy Care & Management • Preventing and Mitigating Nurse Fatigue in Health Care • Prevention of Constipation in the Older Adult Population • Prevention of Falls and Fall Injuries in the Older Adult • Professionalism in Nursing • Reducing Foot Complications for People with Diabetes • Risk Assessment and Prevention of Pressure Ulcers
Red Cross Care Partners	• Assessment and Management of Pain • Developing and Sustaining Nursing Leadership • End of Life Care During the Last Days and Hours • Managing Foot Ulcers in People with Diabetes • Ostomy Care & Management • Risk Assessment and Prevention of Pressure Ulcers
Saint Elizabeth Healthcare (national implementation)	• Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour • Assessment and Device Selection for Vascular Access • Assessment and Management of Pain • Assessment and Management of Stage I to IV Pressure Ulcers • Assessment and Management of Venous Leg Ulcers • BPG for the Subcutaneous Administration of Insulin in Adults with Type 2 Diabetes • Breastfeeding Best Practice Guidelines for Nurses

	• Care and Maintenance to Reduce Vascular Access Complications • Caregiving Strategies for Older Adults with Delirium, Dementia and Depression • Client Centred Care • Crisis Intervention • Decision Support for Adults Living with Chronic Kidney Disease • End of Life Care During the Last Days and Hours • Enhancing Healthy Adolescent Development • Establishing Therapeutic Relationships • Expected and Unexpected Life Events • Managing Foot Ulcers in People with Diabetes • Ostomy Care & Management • Prevention of Falls and Fall Injuries in the Older Adult • Risk Assessment and Prevention of Pressure Ulcers • Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches • Prevention of Constipation in the Older Adult Population • Promoting Continence Using Prompted Voiding • Screening for Delirium, Dementia and Depression in the Older Adult • Stroke Assessment Across the Continuum of Care • Supporting and Strengthening Families Through Expected and Unexpected Life Events
VHA Home Health Care	• Assessment and Management of Pain • Client Centred Care • End of Life Care During the Last Days and Hours • Risk Assessment and Prevention of Pressure Ulcers • Prevention of Falls and Fall Injuries in the Older Adult
VON Canada (national implementation)	• Assessment and Device Selection for Vascular Access • Assessment and Management of Stage I to IV Pressure Ulcers • Assessment and Management of Venous Leg Ulcers • Care and Maintenance to Reduce Vascular Access Complications • Establishing Therapeutic Relationships • Managing Foot Ulcers in People with Diabetes • Prevention of Falls and Fall Injuries in the Older Adult • Reducing Foot Complications for People with Diabetes

Primary Care	
North Bay Nurse Practitioner-led Clinic	• Assessment and Management of Pain • Collaborative Practice Among Nursing Teams • Integrating Smoking Cessation into Daily Nursing Practice • Interventions for Postpartum Depression • Strategies to Support Self-Management in Chronic Conditions: Collaboration with Clients • Woman Abuse: Screening, Identification and Initial Response
Two Rivers Family Health Team	• Adult Asthma Care Guidelines for Nurses: Promoting Control of Asthma • Breastfeeding Best Practice Guidelines for Nurses • Caregiving Strategies for Older Adults with Delirium, Dementia and Depression • Integrating Smoking Cessation into Daily Nursing Practice • Nursing Management of Hypertension • Promoting Asthma Control in Children
Public Health	
Grey Bruce Health Unit	• Breastfeeding Best Practice Guidelines for Nurses • Client Centred Care • Interventions for Postpartum Depression • Prevention of Falls and Fall Injuries in the Older Adult • Primary Prevention of Childhood Obesity
Niagara Region Public Health	• Breastfeeding Best Practice Guidelines for Nurses • Caregiving Strategies for Older Adults with Delirium, Dementia and Depression • Client Centred Care • Developing and Sustaining Nursing Leadership • Enhancing Healthy Adolescent Development • Integrating Smoking Cessation into Daily Nursing Practice • Interventions for Postpartum Depression • Primary Prevention of Childhood Obesity • Screening for Delirium, Dementia and Depression in the Older Adult • Supporting and Strengthening Families Through Expected and Unexpected Life Events • Working with Families to Promote Safe Sleep for Infants 0-12 Months of Age
Thunder Bay District Health Unit	• Breastfeeding Best Practice Guidelines for Nurses • Client Centred Care

	• Enhancing Healthy Adolescent Development • Integrating Smoking Cessation into Daily Nursing Practice • Primary Prevention of Childhood Obesity • Woman Abuse: Screening, Identification and Initial Response
Toronto Public Health	• Enhancing Healthy Adolescent Development • Establishing Therapeutic Relationships • Integrating Smoking Cessation into Daily Nursing Practice • Interventions for Postpartum Depression • Primary Prevention of Childhood Obesity • Supporting Clients on Methadone Maintenance Treatment • Woman Abuse: Screening, Identification and Initial Response

Appendix E
RNAO Position Statement: Strengthening Client Centred Care in Home Care

The Registered Nurses' Association of Ontario (RNAO) strongly supports the development of home care services utilizing a client centred care model in which Ontarians have access to continuity of care and continuity of caregiver from a primary nurse in the most appropriate setting. RNAO also strongly endorses strengthening inter-professional care so all health disciplines work closely together to support high quality client care, ensuring the right care is provided to the right client in the right place by the right care provider. Whether for-profit or not-for-profit, home care organizations must ensure the appropriate nursing care delivery model, skill-mix, and access to Registered Nurses (RNs). Adherence to the principles and spirit of Medicare are paramount to optimal client, staff, organizational and system outcomes. Excellence in client centred home care is supported by four pillars:

- Nursing care delivery models that advance continuity of care and continuity of caregiver by assigning each client one principal nurse, that nurse being an RN or a Registered Practical Nurse (RPN) working to full scope of practice and accountable for delivering the total nursing care required by the client;
- Assignment of the most appropriate caregiver based on the client's complexity of care needs and the degree to which the client's outcomes are stable and predictable, with RNs assigned total nursing care for complex and/or unstable clients with unpredictable outcomes, and RPNs assigned total nursing care for stable clients with predictable outcomes. Clients whose condition is unclear remain under the care of RNs to prevent shifting a client back and forth between RNs and RPNs. When unregulated staff are utilized, they are assigned to assist RNs or RPNs where appropriate and under their supervision, avoiding disruption of the continuity of care provided by the assigned nurse;
- Workforce stability, by achieving 70 per cent full-time employment for all nurses, supports continuity of care and continuity of caregiver, improves intra and inter-professional team work, reduces costs and facilitates staff satisfaction and retention; and
- Investment in publically funded not-for-profit home care services supports universal access to necessary home care when and where it is needed in the spirit of the Canada Health Act.

Background

Vibrant communities depend on everyone having the opportunity to live at home with dignity as independently as possible whatever their background, wherever they live and whenever possible. Home care agencies support vibrant communities by providing a range of services from post-hospitalization follow-up to homemaking and personal support services. These services enable people with acute and chronic conditions to remain active and strong members of our community.

In 1997 the provincial government of the day instituted managed competition as the sole service delivery model in Ontario's home health care system. In January 2008, Hamilton residents protested the disqualification of two long-standing not-for-profit home care agencies in the bidding process; namely the Victorian Order of Nurses (VON) and St. Joseph's Home Care.

A province-wide moratorium was subsequently placed on the competitive bidding of home care contracts. In December 2008, the government chose to resume competitive bidding and quietly lifted the moratorium. Various accountability measures were announced at the time and accreditation is now required for all service contracts. There are, however, no current plans to issue Request for Proposals (RFPs), subject to Ministry of Health and Long-Term Care (MOHLTC) Directives for CCAC Procurement. Instead, contracts are being extended based on compliance with CCAC requirements. An integrated strategy is required to avoid unnecessary system costs. Increasing access to home care and community services, for example, enables patients in alternative level of care (ALC) beds to leave hospital sooner, availing beds to patients in emergency rooms who are waiting to be admitted to hospital." In 2009, 50,000 patients stayed longer than necessary in hospital waiting for discharge care to be arranged. This waste accounted for 16 per cent of all hospital patient days.

Competitive bidding is antithetical to client centred care as it inevitably leads to home care contracts awarded on the basis of price rather than quality. Ontario remains the only province relying exclusively on competitive bidding and home care is the only health sector in Ontario where direct care is contracted out. North American jurisdictions that have implemented competitive bidding conclude this model reduces wage costs but generates higher turnover and reduces continuity of care.

Successful models of care delivery across the country should be considered instead, including innovative models such as the publicly administered and cost-effective SIPA (French acronym for Système de services Intégrés pour Personnes Agées en perte d'autonomie) model in Quebec.

Access to Registered Nurses

Access to registered nurses in all sectors is essential to achieve optimal health outcomes. While access to RNs and home care services is increasing in certain LHINs, access is not equal across the province.

When health care restructuring occurred in the 1990's unprecedented cuts were made to home care services awarded to various agencies by Ontario's Community Care Access Centres (CCACs). Since that time home care funding has fluctuated with little consistency in service delivery expectations or quality indicators. Currently health care dollars are severely limited leading certain CCACs to restrict funding for much needed nursing and personal care services. This restriction has dramatically increased service wait times and effectively reduced required access to nurses.

Client centred care requires a reconceptualization of the client as one who lives within a family unit. This concept prompts recognition that restricting access to RNs inevitably shifts care

responsibilities to family members. Often families do not have sufficient resources to manage the burden of care in addition to their other responsibilities. The additional burden may cause detrimental effects on family well-being as well as increased safety risks and diminished quality of care for clients. Advances in treatments and technology, limited resources, decreased length of hospital stay, increased day surgery treatment and changes in consumer expectation have significantly increased the care requirements of today's community client. While there is limited evidence that relates care provided by RNs with better health outcomes in home care, convincing evidence from both hospital and LTC sectors demonstrate that increasing the proportion of RNs is effective in improving client outcomes and reducing cost.

RNAO Best Practice Guidelines

RNAO has developed evidence-based Healthy Work Environment Best Practice Guidelines (BPGs) that, when applied, serve to support the excellence in service that home care nurses are committed to delivering. Relevant guidelines include: Developing and Sustaining Effective Staffing and Workload Practices, and Collaborative Practice among Nursing Teams. These BPGs should be used as markers in all staffing and scheduling practices and models of nursing care delivery. RNAO also has numerous clinical BPGs relevant to community health nursing. These include:

- Client Centred Care,
- Decision Support for Adults: Living with Chronic Kidney Disease,
- Reducing Foot Complications for People with Diabetes,
- Supporting and Strengthening Families through Expected and Unexpected Life Events.
- Assessment and Management of Pain,
- And many others

Definitions

For the purpose of the Strengthening Client Centred Care in Home Care Position Statement, the following BPG definitions apply:

- Client centred care: "an approach in which clients are viewed as whole persons. It is not merely about delivering services where the client is located. Client centred care involves advocacy, empowerment, and respecting the client's autonomy, voice, self-determination and participation in decision-making."
- Skill mix: "the distribution of nursing personnel per skill category (i.e. RN, RPN) and per skill level."

Four Pillars Strengthening Client Centred Care:

Pillar 1: Continuity of Care & Continuity of Caregiver

Continuity of care and continuity of caregiver are fundamental to client centred care. As set out in RNAO's Client Centred Care Best Practice Guideline, continuity of care and continuity of caregiver enables nurses to provide holistic client care, facilitate coordination of services based on changing client needs, and create clear accountability. Researchers and decision-makers are currently examining continuity of care as a variable in quality care outcomes. In one recent Ontario-wide home care study involving 740 home care clients and 700 nurses, clients received, on average, 67 per cent of their visits from the same nurse. Only 22 per cent of clients had all of their visits by the same nurse and only 34 per cent of the sample had 80 per cent or more of their visits by the same nurse.

Consistency of care provider is challenging in home care since clients may require more than one visit per day, require weekend care, are admitted on a Friday or Saturday, or the level of client predictability, stability or complexity changes resulting in a transfer of care from RN to RPN or vice versa. Continuity of a principal caregiver is important to client care because the nurse must keep track of changes, or a lack thereof, in the client's condition. They must also detect subtle changes in the client's appearance or demeanor that indicate changing client needs and note accurate observations when communicating with the physician about any deterioration in the client's health.

One consequence of competitive bidding is that many clients risk being shuffled to a different agency to begin a new therapeutic relationship with a new nurse. Rural and elderly populations are especially affected by this loss of continuity as nursing and home visits are an important source of social support and interaction. In these instances, managed competition reduces the client's power by discontinuing therapeutic relationships and diminishing the client's control over their choice of care provider. One recent study found a significant relationship between longer service contracts and greater consistency of principal nurse visits, suggesting that nurse scheduling and assignment may be optimized by fewer contract changes. Currently, "independent CCAC client satisfaction surveys indicate that home care clients are generally satisfied with the services they receive".

While CCACs have set standards for continuity and the acceptable number of caregivers for each client, based on number of visits required per month, home care clients may soon experience care provided by a team of practitioners based on their particular condition(s) / diagnosis rather than a principal care provider such as an RN. The Integrated Client Care Project announced in 2009 as a key component of Minister Caplan's "Strengthening Home Care Services in Ontario", focuses on "specialization, integration and coordination". This new model may improve quality of care for clients while providing nurses with more autonomy in clinical decision-making and time allowances. Throughout the inevitable restructuring it will be important for health care practitioners and service providers to ensure holistic care is provided and continuity of care and continuity of caregiver remain optimized.

Pillar 2: Most Appropriate Care Provider

Choosing the most appropriate care provider based on the complexity of client's care needs and the predictability of the client's outcomes is central to client centred care and ensures clear accountabilities:

Each client is assigned one principal nurse (RN or RPN) who works to his/her full scope of practice and is responsible and accountable for delivering the total nursing care required by that client;
The client's assignment of an RN or an RPN is based on the level of complexity of the client's condition, care requirements and predictability of the client's outcomes, with RNs assigned the total nursing care for complex or unstable clients with unpredictable outcomes and RPNs assigned the total nursing care for stable clients with predictable outcomes;

Clients whose condition is unclear remain under the care of an RN to prevent shifting clients back and forth between RNs and RPNs; and, Unregulated staff assist the RN or RPN as appropriate and under their supervision, without disrupting the continuity of care provided by the assigned nurse.

RUG (Resource Utilization Group) scores derived from RAI MDS (Resident Assessment Instrument Minimum Data Set) Community Health Assessments (CHA) indicate the intensity and complexity of care that long-stay clients receive; a useful tool in determining which client should receive care by RN vs RPN or UCP.

Funding policies that have given rise to competitive bidding and privatization of services have caused unwarranted introduction of inappropriate skill mix applications. RNs must always assess the complexity, stability and predictability of each admission to home care services in order to coordinate safe and high quality care. This is particularly warranted in post-hospitalization and post-surgical admissions. Use of eligibility screening-tools by non-regulated staff to prioritize clients' health care needs and to select service providers is inadequate for a safe and comprehensive assessment. Safe and high quality community nursing assessments require fostering client trust within a therapeutic nurse-client relationship. Once a relationship is established, a tremendous degree of skilled judgement is required to conduct a comprehensive assessment that sufficiently identifies care needs that are not always obvious or stated at intake. RNs who assess and continue caring for clients who are complex, unstable and unpredictable are exemplifying continuity of care and continuity of caregiver. RNs who recognize within their assessment, the need for a timely referral of care to an RPN or UCP are also exemplifying this care. In this manner, continuity of care and continuity of caregiver allows every health care provider to participate in and be accountable for the entire care process; essential for client safety, quality outcomes and staff satisfaction.

The assumption that RN care is financially unsustainable is not supported by the available, albeit, limited evidence. According to one recent University of Toronto report, the percentage of RN visits in home care was positively related to better emotional and social functional outcomes for clients. Home care agencies seeking to improve quality while reducing risk and unnecessary

costs associated with staff turnover should be looking at strengthening their full-time RN workforce.

Pillar 3: Workforce Stability

Continuity of care and continuity of caregiver must be supported by full-time employment practices in all sectors. A level of 70 per cent full-time employment for all nurses is considered the minimal condition for ensuring continuity of care and continuity of caregiver for clients. Evidence shows that workforce stability, with higher proportions of full-time RN staff, is significantly associated with continuity of care and continuity of caregiver, and with lower mortality rates and improved client outcomes. Conversely, excessive use of part-time and casual employment for RNs is associated with decreased morale, an unstable workforce where nurses move to other jurisdictions to find full-time work, disengagement among nurses, and lack of continuity of care for clients.

The number of home care visiting nurses in Ontario decreased between 1999 and 2009 from 7546 to 5,007 despite increased population and increased need for community health services. In the same ten year period casual positions decreased from 30.7 per cent to 19.3 per cent and FT positions increased from 36.2 per cent to 48.7 per cent. While encouraging, this percentage of FT RNs is well below the total nursing average of 65.4 per cent FT employment. The proportion of PT visiting nurses has remained steady over the past 10 years at 32 per cent; however 16 per cent of PT community nurses would prefer FT employment. Given this demand, home care FT employment could reach as high as 64.7 per cent. In stark contrast to home visiting nurses, the total number of CCAC nurses / case managers increased from 1668 to 3281 in the past decade moving from 68.6 per cent to 73.6 per cent FT work. Increasing the number of CCAC nurses while decreasing visiting nursing positions may reduce, or at least be perceived as reducing, funds available to ensure accessibility and appropriate workloads of direct care staff.

With the implementation of managed competition and concurrent privatization, cost-cutting measures have resulted in the intensification of work in home health care. This has impacted workforce stability in a profound way. According to provider organizations, threats to workforce stability include: challenges to meet goals with insufficient funding; high turnover rates (home care had an attrition rate of 15 per cent in 2007); difficulties in recruitment; an aging workforce (average age is 45); lack of regular hours; and, a large disparity in compensation between home care and other health care sectors. Wage disparity led OHHCPA and OCSA to recommend a 50 per cent increase in compensation in 2000. Many providers have suggested there should be an ongoing mechanism to review CCAC / Ministry base funding to avoid cyclical wage disparity between sectors.

While wages remain low, workload has risen sharply. Frontline staff is being asked to provide an increased level of service in a reduced amount of time. Nursing visits from 2008 to 2009 increased by 89,055, while 46 fewer nurses were employed. The marginally increased FT employment during this time could not have addressed the increased number and acuity of home care visits. Intensifying work by coordinating clinics to serve multiple clients at the same time may be justified as long as clinics succeed in meeting clients' individual needs and the nurse-

client therapeutic relationship is preserved. Recent research shows that nurses paid on a per-visit basis rather than an hourly basis were less satisfied with their job . Those paid hourly were more satisfied with their time for care suggesting work intensification without reciprocal social and monetary rewards may lead to low staff morale. Researchers have pointed to high levels of stress, burnout, and physical health problems, concluding that restructuring home care services resulted in numerous work environment concerns that may be leading to decreased job satisfaction, increased absenteeism, and increasing fear of job loss along with a stronger propensity to leave.

Certain retention and recruitment efforts in home care have served to weaken client centred care and must be eliminated. Despite RNAO's attempts to eliminate the "elect-to-work" model, and the MOHLTC's recommendation to do the same, this practice continues to date and in 2007 replaced approximately 788 FTE RNs with casual / elect to work staff. Retention and recruitment efforts instead should focus on the reasons nurses choose home care: flexible hours; dissatisfaction with institutional nursing; ability to have 1:1 relationships with clients and not feel rushed; preference for independence in practice; avoid night shifts; enjoy the variety; minimal weekend work; and more time with family.

Pillar 4: Publically Funded and Not-for-profit Home Care Services

The percentage volume of nursing services provided by for-prof¬it provider agencies rose from 18 per cent in 1995 to 46 per cent in 2001. By 1997 for-profit businesses were awarded more than 50 per cent of the Ontario contracts. Since the rise of for-profit agencies managed competition has been diverting funds away from direct care and into costs associated with the competitive bidding process and into the pockets of shareholders. Lower wages and reduced access to adequate supplies are noted more often in for-profit than in not-for-profit Canadian home care agencies.

While for-profit businesses are praised for their incentive to be cost-conscious and innovate, not-for-profit providers compete with a distinct disadvantage. Many not-for-profit providers have a long term employment history and when the employer loses a contract, they are subject to very high severance payouts. For-profit agencies rely more on a casual pool of workers and are not impacted to the same degree financially. According to one study, more nurses from not-for-profit agencies were employed on a full-time basis than for-profit agencies (35 per cent versus 26 per cent).

Additional Organizational Processes

Additional organizational supports that strengthen client centred care in home care and strengthen inter-professional collaboration include: 1) nurse managers with a span of control that supports their engagement with staff; and 2) better utilizing the knowledge and skills of registered nurses in different roles, such as Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs). As clients are being discharged from hospital at a more acute stage of recovery, or are waiting for placement into a long term care home, the sustainability of the home

care workforce is critical to the sustainability of health care in Ontario and the health of Ontarians.

The anticipated demand for home care services and nurses in home care is expected to increase to 9 per cent of the total nurse demand by 2020. This requires the development of both short and long term strategies to ensure nursing human resources will be able to meet growing client care needs in the community. A comprehensive national home care strategy following the same principles and spirit of the Canada Health Act enables people to live with dignity and as independently as possible in their own communities. Current initiatives, such as the Integrated Client Care Project, provide hope for a more effective, integrated, funded and balanced era of home care service delivery in the near future.

Conclusion

Evidence suggests that nursing models of care that advance continuity of care and continuity of caregiver from the most appropriate nurse ensure safe, high-quality client centred care. The most appropriate principal nurse, RN or RPN, is assigned based on the client's complexity and care needs and the degree to which the client's outcomes are predictable. Altering evidence-based skill-mix applications to employ less skilled staff compromises nursing practice and client outcomes. Service providers must stabilize the home care workforce by employing a ministry mandated 70 per cent full time workforce of nursing staff equitably compensated at parity with nurses who provide care in hospital settings. Finally, the government must consider the overwhelming evidence against managed competition and advocate for a comprehensive national home care strategy that supports readily accessible publicly funded not-for-profit home care services to enable people to live with dignity and as independently as possible in their communities.

See complete PDF with Footnotes and Glossary at:
http://rnao.ca/sites/rnao-ca/files/RNAO_Position_Statement_Strengthening_Client_Centred_Care_in_Home_Care.pdf

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