RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Transforming Ontario's Health System: A Recipe for Success

Response to the Ministry of Health and Long-Term Care's *Patients First: Proposal to Strengthen Patient-Centred Health Care in Ontario*

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Executive Summary

The Registered Nurses' Association of Ontario (RNAO) is delighted to provide feedback to Ontario's Minister of Health and Long-Term Care Dr. Eric Hoskins' *Patient's First Discussion Paper.* We begin with a brief summary in the form of a table to facilitate a high-level overview of RNAO's responses to the various proposals in the Minister's paper. This brief executive summary is followed by the full submission, which provides a more detailed analysis of each component of the paper, along with identified enablers for success.

RNAO urges Minister Hoskins to be bold and visionary, so that restructuring leads to real change that improves Ontarians' health experiences, their outcomes, and their health systems' cost effectiveness.

Patient's First Proposal	**RNAO's Recommendations**
Proposal #1	
Provide care that is more integrated and responsive to local needs. Make LHINs responsible and accountable for all health service planning and performance. (p.13)	1) Enable LHINs to plan, integrate, fund, monitor and be ultimately accountable for local health system performance while refraining from service delivery and management.
Identify smaller regions as part of each LHIN to be the focal point for local planning and service management and delivery. (p.13)	2) Proceed with sub-LHIN regions to facilitate horizontal primary care integration and ensure they serve to improve services for patients and not create barriers, unnecessary new bureaucracy, or new governance layers.
Proposal #2	
Bring the planning and monitoring of primary care closer to the communities where services are delivered. LHINs, in partnership with local clinical leaders, would take responsibility for primary care planning and performance management. (p.15)	3) Empower LHINs to oversee the planning, performance and contract management and funding of all primary care entities.
Set out clearly the principles for successful clinical change, including engagement of local clinical leaders. (p.15)	4) Ensure that clinical leadership roles are inclusive and incorporate a range of regulated health professionals

Patient's First Proposal	RNAO's Recommendations
… enable the approach to Patient-Centred Medical Homes as recommended by the Ontario College of Family Physicians and others. (p. 16)	5) Avoid the "Medical Home" model. Instead, make interprofessional primary care the foundation of Ontario's health system and the key priority for LHIN and Ministry planning efforts. Grow and expand the capacity of the primary care sector.
Proposal #3	6) Move forward with substantive health system transformation that includes true realignment of all necessary CCAC functions and services within existing areas of the health system. 7) Reallocate any savings from the elimination of CCACs into service provision with a focus on increasing hours of direct home health-care and support service delivery and mental health and addictions care. 8) Do not transition CCAC executive positions to the LHINs. 9) Transition mental health nurses in schools into public health units and the mental health sector. Transition NPs to appropriate primary care and home health-care/support service providers. 10) Locate the 3,500 CCAC care co-ordinators within primary care organizations through a secondment and develop provincial standards for care co-ordination and system navigation based on RNAO's implementation advice.
Strengthen accountability and integration of home and community care. Transfer direct responsibility for service management and delivery from the CCACs to the LHINs. (p. 18) CCAC employees providing support to clients would be transitioned to, and employed by, LHINs. (p. 18) Home care co-ordinators would be focused on LHIN sub-regions, and may be deployed into community settings (such as family health teams, community health centres or hospitals). (p. 18)	
Proposal #4	11) Formalize relationships between public health units and the LHINs and identify a primary LHIN for those units that span multiple LHIN boundaries.
Integrate local population and public health planning with other health services. Formalize linkages between LHINs and public health units. (p. 20)	

Key enablers to achieve bold and visionary transformation:

1) Amend the *Local Health System Integration Act* to make health promotion, community development and health equity expectations of the LHINs.
    a. Require LHINs to engage in a health equity assessment for all planning and funding decisions.
2) Develop an interprofessional health human resource plan to align population health needs and the full and (where appropriate) expanded scope of practice of all regulated health professionals with system priorities. In the meantime, issue an immediate moratorium on the replacement of RNs with less qualified providers.
3) Put a stop to fragmented organizational models of nursing care delivery and support primary nursing models that enable total patient care.
4) Bridge compensation gaps that exist for primary care NPs through the roll-out of the $85M committed to do so in the 2016 provincial budget.
5) Strengthen the Ministry's role as a steward of Ontario's health system through the adoption of consistent planning standards across the province.
6) Identify a short, medium, and long-term vision for delivering and expanding interprofessional primary care in the province. Critical enablers include:
    a. Adopting an independent model of RN prescribing, coupled with the authority to order diagnostic testing and communicate a diagnosis.
    b. Remedying outstanding scope of practice issues for NPs.
7) Enable supportive environments and resources that promote evidence-based practice as the norm.
8) Evaluate the process and outcomes of health system transformation efforts at the patient, provider and system level.

Transforming Ontario's Health System: A Recipe for Success

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses (RN), nurse practitioners (NP) and nursing students in all roles and settings in Ontario. We are pleased to respond to Minister Hoskins' request for feedback on the discussion paper released December 17, 2015: *Patients First – A proposal to strengthen patient-centred health care in Ontario*.[i]

RNAO applauds the Ministry of Health and Long-Term Care for bringing forward innovative ideas that will enhance the structure of the health system and service delivery in Ontario.[ii] RNs, NPs and nursing students are eager for bold system change and see themselves as catalysts for transformation. RNAO was pleased to be credited in the Minister's document as having informed his proposal. Indeed, much of RNAO's *Enhancing Community Care for Ontarians* (ECCO) model[iii], which was first issued in 2012 and again in 2014, is reflected in Minister Hoskins' *Patients First* proposal. The context underpinning the Minister's proposal is abundantly clear: rising health expenditures, suboptimal access to services, duplication, inadequate outcomes, and inefficiencies. These are challenges that RNAO has highlighted for many years. We commend the Minister for listening to the calls to action, and are delighted to provide a comprehensive review of the discussion document, along with system-level recommendations for the Ministry and LHINs.

Most of all, we urge the Minister to be bold and visionary, so that restructuring leads to real change that improves health system experience, outcomes and cost-effectiveness.

Feedback on Proposal #1 - More Effective Integration of Services and Greater Equity

This proposal would extend the reach of the LHINs to become responsible for local health service planning and performance. It would also create sub-LHIN regions as a focal point for local planning. This proposal is largely consistent with RNAO's position regarding LHINs in ECCO[iv] by placing greater emphasis on integration across all sectors according to population needs and context. It would support the LHINs in partially accomplishing what they were envisioned to deliver: whole system planning and integration, funding allocation, managing service agreements, monitoring and accountability functions. We know that some of the limitations of LHINs today stem from their inability to plan for an entire local health system, which has created an experience similar to that of an airplane flying with a single wing.

However, there is a crucial element that is missing from the proposal: positioning the LHINs as the single health system funder. To effectively plan and manage performance in a way that will produce meaningful integration across the system, LHINs must be enabled to enter into service agreements with providers across sectors. Without this component, LHINs will lack the capacity to reallocate resources as services shift from one sector to another.

A second major concern from RNAO is the proposal's reference to LHINs' involvement with service delivery. RNAO profoundly disagrees with such a role as it perpetuates the problems seen in Community Care Access Centres (CCAC). As we have captured in RNAO's ECCO report, the most effective role of the LHIN is to plan, integrate, fund, monitor and be ultimately accountable for local health system

performance. It would be ineffective for LHINs to engage in direct service provision. It is challenging to "row" and "steer" at the same time. Further, it is unclear what the proposal's definition of "service management" entails. RNAO urges the Ministry not to perpetuate the existing limitations of CCACs by acting as a case management brokerage that allocates hours of service to Ontarians based on a command and control approach. Rather, service provision and the management of service, including service allocation at the patient level, should be the focus of provider organizations that have the best understanding of patient need.

RNAO is eager to see the development of sub-LHIN regions for their potential to enable horizontal primary care integration. We encourage the Ministry to leverage existing research, including the work of the Institute for Clinical Evaluative Sciences (ICES). The formation and operation of sub-LHINs should only serve to improve services for patients and not create access barriers, unnecessary new bureaucracy, or new governance layers. The mapping of these networks should consider health service utilization patterns, population health needs, geography, service distribution, health human resources, socioeconomic/cultural data, and crossover implications (i.e. those who cross boundaries to seek service). The mapping process cannot solely be a top-down exercise, and must include robust consultation at the local level. This inclusive consultation should be led by the LHINs and engage system stakeholders, the public and service providers.

The Minister's proposal aims to bring health system planning to the local level. However, mechanisms for patient/family engagement are missing. It is important to consider how to meaningfully engage the patient/family voice in policy and planning discussions. A central goal should be to identify what the expectations and desired outcomes are for patients, and to build corresponding policy that will deliver these expectations/outcomes. RNAO has long recommended the creation of patient/family councils as a mechanism to bring the patient perspective to health system planning and decision-making.[v]

Recommendation #1: Enable LHINs to plan, integrate, fund, monitor and be ultimately accountable for local health system performance while refraining from service delivery and management.

Recommendation #2: Proceed with sub-LHIN regions to facilitate horizontal primary care integration and ensure they serve to improve services for patients and not create barriers, unnecessary new bureaucracy, or new governance layers.

Feedback on Proposal #2 - Timely Access to Primary Care, and Seamless Links Between Primary Care and Other Services

This proposal would bring the planning and monitoring of primary care into the LHIN mandate. However, physician funding and contracts would continue to be managed by the Ministry. RNAO has long called for primary care to be included within the LHIN mandate[vi] and urges the Ministry to take the proposal one step further by empowering LHINs to oversee the planning, performance and contract management and funding of all primary care entities. Doing so will help integrate care across the continuum, enhance performance management, support performance improvement, and lead to a better experience for patients and their families.

RNAO urges the Ministry to require LHINs to make primary care the foundation of their regional system planning and service delivery efforts. From this standpoint, any decision made by the LHINs must consider its relationship to primary care and the impact it will have on the ability of primary care to be the foundation of the system.

RNAO is concerned with the current implementation of integrated funding models, specifically the impact they have on primary care.[vii] For example, the current approach to integrated funding pioneered by St. Joseph's Health Care Hamilton advances a model of care co-ordination that is rooted within hospitals.[viii] This is troubling for several reasons. First, the highest performing health systems in the world have primary care as their foundation, and use it to co-ordinate care delivery.[ix] Second, hospitals are the most costly sector of Ontario's health system[x] and their culture is based on illness care. By contrast, primary care is rooted in health promotion, prevention, and early intervention. Third, hospital-based care co-ordination is designed to be episodic and leads to fragmentation. Finally, and most important, people want to receive care as close to home as possible.

Enabling primary care-based co-ordination will drive continuity and comprehensiveness through a long-term therapeutic relationship. LHINs and the Ministry must advance funding models that will enable and not inhibit a transformation to bring care as close to home as possible through primary care. While hospitals may be seen as possessing infrastructure capacity and readiness/ability to take on new initiatives, there is a growing capacity, readiness, and eagerness within primary care through high performing interprofessional primary care organizations. Moreover, primary care as a whole must be enabled and supported to assume a greater leadership role within the health system. Not doing so is tampering with health system leaders and a sector that is ready to be engaged and unwavering in its commitment to serve the public, from cradle to grave. RNAO believes that an enabler of this growth will be through the creation of sub-LHIN regions that will help to stimulate horizontal primary care integration and connectivity.

A key enabler of success for the Minister's proposal is engagement of clinicians. It is encouraging to see that the paper makes reference to the designation of "local clinical leaders." However, it is imperative that these leadership roles are inclusive and incorporate a range of regulated health professionals, including: nurses, physicians, pharmacists, physiotherapists, midwives, etc. RNAO has long advocated for tripartite leadership networks at LHINs that include representation from medicine, nursing and one other regulated health profession.[xi] Doing so ensures that the perspectives of multiple professions are

incorporated. Furthermore, RNAO recommends that the Ministry, in its stewardship role, support each of the LHINs to consistently engage in broad and inclusive consultations with all providers and system partners. This engagement will be essential to deliver the best possible results for Ontario's health system.

RNAO is alarmed to see reference to the "Patients Medical Home" vision in the paper. The medical home model as articulated by the College of Family Physicians of Canada (CFPC) makes an explicit goal to: "... ensure that every patient has a personal family physician who will be the most responsible provider (MRP) for his or her medical care."[xii] RNAO fully supports interprofessional care and sees it as a key enabler to the Minister's vision for health system transformation. However, we cannot support the medical home vision, as currently described by the CFPC, as it runs counter to the significant progress Ontario has made in achieving team-based care. For example, pursuing a medical home model would jeopardize Ontario's NP-led clinics, where nearly 50,000 Ontarians are benefiting from team-based primary care and have an NP as their clinical lead. At these locations, physicians serve in a consultative capacity. Similarly, Ontario's Community Health Centres, which demonstrate positive outcomes for Ontarians with the most complex social and medical needs,[xiii] offer team-based care and a physician is not necessarily an MRP. Moreover, research has not demonstrated the effectiveness of the medical home model in the United States. Friedberg et al (2014) found that: "A multipayer medical home pilot, in which participating practices adopted new structural capabilities and received NCQA certification, was associated with limited improvements in quality and was not associated with reductions in utilization of hospital, emergency department, or ambulatory care services, or total costs over three years. These findings suggest that medical home interventions may need further refinement."[xiv] This has led to some commentators recommending against a generic one-size-fits-all approach that the medical home has produced.[xv]

While RNAO disagrees with CFPC's vision for establishing medical homes, as currently stated, we do agree with positioning interprofessional primary care as a persons' "health hub" to co-ordinate broad health needs. Using the term "medical home" implies limiting primary care to delivering medical services. This is a very narrow approach that will not result in health equity or a state of primary health care, and undermines the sector's growing capacity to address all of a person's health and social needs. Rather than focus on fostering medical homes, RNAO urges the Ministry to place emphasis on expanding current team-based delivery models, improving timely access to services and positioning primary care to serve as the foundation of the health system.

Recommendation #3: Empower LHINs to oversee the planning, performance and contract management and funding of all primary care entities.

Recommendation #4: Ensure that clinical leadership roles are inclusive and incorporate a range of regulated health professionals.

Recommendation #5: Avoid using the "Medical Home" model. Instead, make interprofessional primary care the foundation of Ontario's health system and the key priority for LHIN and Ministry planning efforts. Grow and expand the capacity of the primary care sector.

Feedback on Proposal #3 - More Consistent and Accessible Home and Community Care

This proposal involves the elimination of the boards of Community Care Access Centres (CCAC) and a transition of its functions to the LHINs. RNAO supports this proposal, provided that it entails elimination of the CCAC as a structural entity. RNAO urges the Minister to proceed with true realignment that does not simply re-position CCACs to exist within LHINs. Meaningful change is needed to reduce duplication, enhance efficacy, and improve the integration of services.

The Auditor General of Ontario has identified that while CCACs reported that 92 per cent of their $2.4B budget went to direct patient care, only 61 per cent was spent on face-to-face treatment of patients.[xvi] Implementation of the Minister's plan to eliminate CCACs will produce administrative savings that can be reinvested into other areas of the health system. RNAO expects that up to $200M annually could be reallocated and recommends that these funds be used in service provision, including increasing hours of home health-care and support services, and improving the capacity of primary care providers to deliver mental health services and palliative care.

The Ontario Primary Care Council (OPCC) asserts that care co-ordination is a core function of primary care.[xvii] As RNAO has previously urged, current CCAC care co-ordinators, of which approximately 3,000 are RNs, should be located within primary care with their salary and benefits intact.[xviii,xix] Increasing the workforce capacity of primary care will significantly improve primary care's ability to deliver comprehensive health services. We respect the collective agreements that have been struck and encourage the Ministry, unions, and primary care to work together to develop a transition strategy that is fair to workers and in the best interest of Ontarians. Our hope is that the care co-ordinators are fully embedded (located and employed) within primary care in five years. In the meantime, RNAO calls for a matrix reporting structure. While the collective agreement and funds would be held by the LHIN, we encourage the Ministry to ensure that primary care organizations are enabled to serve as the operational employer, which involves recruitment and performance management. This can be best accomplished through a secondment model.

RNs possess a comprehensive understanding of the health system and a persons' holistic health status, including physical, mental, social, emotional and spiritual needs. Their competencies, knowledge and clinical skills make them uniquely suited to function as leaders in the co-ordination of care and navigation of the system. As profiled in RNAO's *Primary Solutions to Primary Care*[xx] and in ECCO,[xxi] RN-led and primary care-based co-ordination align hand-in-glove to produce positive patient and health system outcomes.

RNAO calls for the development of provincial standards to guide care co-ordination and health system navigation in primary care. We envision a care co-ordination and navigation role that extends beyond the organization/brokerage of home and community care services. Creation of sub-LHIN networks will be an excellent means of guiding the location of the care co-ordinators within primary care. RNAO encourages the Ministry to consider the Solo Practitioners in Need (SPiN) project, delivered through the Mid West Toronto Health Link and Access Alliance CHC, and/or the Rural Hastings Health Link, co-ordinated through Gateway Community Health Centres, as models for how this could be implemented.[xxii] [xxiii] Please see appendix A for operational advice.

A key indicator of effective care co-ordination is a seamless journey and transition throughout the health system. Interoperable electronic health records are essential for delivering this success. More effort is needed to strengthen connectivity and communication among care providers. Having dedicated care co-ordinators within primary care can champion this success. However, leadership at the provider, organization, LHIN, and provincial levels is needed to support electronic communication and appropriate data sharing.

RNAO recommends that mental health nurses in schools, currently employed by CCACs, be transitioned into public health units for those who meet the legislated definition of a public health nurse (RN with a baccalaureate degree). This would complement the work of public health units to expand an important presence of public health nurses in schools. For those nurses who do not meet the eligibility for becoming a public health nurse, we recommend they be utilized elsewhere in the existing mental health sector. We also encourage the placement of NPs currently practising within CCACs to appropriate primary care and home health-care/support service providers.

While the administrative capacity of the LHINs needs to be strengthened to fulfill an expanded role, RNAO cautions against the automatic transition of CCAC executive positions to the LHINs at their current compensation level. This is not meant to diminish the individuals occupying these positions, rather the financial implications of such a transition. Currently, the compensation of CCAC executives is comparable to LHIN executives. Transitioning CCAC executive positions within the LHIN would demand a considerable increase to the compensation of LHIN executive positions, given the scope and breadth of their role. One solution is to provide CCAC executives with a working notice of one year to either seek a new role within the LHIN or pursue employment elsewhere.

Recommendation #6: Move forward with substantive health system transformation that includes true realignment of all necessary CCAC functions and services within existing areas of the health system.

Recommendation #7: Reallocate any savings from the elimination of CCACs into service provision, with a focus on increasing hours of direct home health-care and support service delivery and mental health and addictions care.

Recommendation #8: Do not transition CCAC executive positions to the LHINs.

Recommendation #9: Transition mental health nurses in schools into public health units and the mental health sector. Transition NPs to appropriate primary care and home health-care/support service providers.

Recommendation #10: Locate the 3,500 CCAC care co-ordinators within primary care organizations through a secondment and develop provincial standards for care co-ordination and system navigation based on RNAO's implementation advice.

Proposal #4 - Stronger Links Between Public Health and Other Health Services

This proposal would formalize a relationship between Ontario's 36 public health units and the LHINs. Specifically, the LHINs would oversee provincial funding allocation and contract management, while maintaining current public health unit structures, boundaries and governance (local boards of health). RNAO has long advocated for this change and welcomes it. Public health units must assume a leading role in advancing health equity. They are experts in upstream health promotion and disease prevention, as well as analyzing population health needs and delivering community engagement. This alignment will benefit the LHINs' system planning efforts. Positioning public health units within the LHIN mandate will better align public health with the rest of the system, and can stimulate a broader reach of health promotion principles in other sectors.

However, there are implementation considerations that must be adopted. First, the current public health boundaries do not align with the boundaries of the LHIN. This is similar to the past when CCAC boundaries were inconsistent with LHIN boundaries. In areas where a health unit is positioned within multiple LHIN boundaries, it will be important that one LHIN is designated to serve a primary role for funding and accountability purposes. Relationships should be maintained with the other LHIN(s), however, having a single primary contact will help to strengthen the delivery of public health services, optimize communications, and avoid fragmentation. Once all sectors are within the LHIN mandate and Ontario is closer to achieving a fully integrated health system, it will be opportune to examine whether existing boundaries are consistent with optimal service delivery and health outcomes for Ontarians.

Lastly, Boards of Health in Ontario are meant to represent the principles of a public health approach. The *Ottawa Charter for Health Promotion* identifies advocacy as a key pillar to securing good health. Therefore, it is imperative that in a transformed health system, public health units and their boards are fully able and supported to engage in evidence-informed advocacy for healthy public policy.

Recommendation #11: Formalize relationships between public health units and the LHINs, and identify a primary LHIN for those units that span multiple LHIN boundaries.

Enablers of Success

a) Health Equity

The World Health Organization defines and understands health equity as "the absence of unfair or remediable differences in health among population groups defined socially, economically, demographically or geographically. In essence, health inequities are health differences that are socially produced, systemic in their distribution across the population, and unfair."[xxiv] This is consistent with the National Collaborating Center on Social Determinants of Health framing of health inequities as avoidable and the "result of how societies distribute resources and opportunities."[xxv] The United States Office of Disease Prevention and Health Promotion defines health disparities as: "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[xxvi] The Health Equity Institute at San Francisco State University recommends the following steps ought to be taken to achieve health equity:[xxvii]

- Attention to the root causes of health inequities and health disparities, specifically health determinants.
- Particular attention to groups that have experienced major obstacles to health associated with socio-economic disadvantages and historical and contemporary injustices.
- Promotion of equal opportunities for all people to be healthy and to seek the highest level of health possible.
- Distribution of socio-economic resources needed to be healthy in a manner that progressively reduces health disparities and improves health for all.
- Continuous efforts to maintain a desired state of equity after avoidable health inequities and health disparities are eliminated.

It is encouraging to see an entire section of the Minister's discussion paper highlighting the need to improve health equity and reducing health disparities, with a particular emphasis on First Nations, Métis and Inuit Peoples, Franco-Ontarians, members of other cultural groups (particularly newcomers), and persons experiencing mental health and addiction challenges.[xxviii] We urge the Minister to work collaboratively with those who have lived experience in the above groups, along with inter-Ministerial collaboration and engaging other stakeholders to advance health equity in Ontario. A critical planning assumption must be that attainment of health equity demands solutions that are derived from the ground up.

While the objectives of the LHINs in the *Local Health System Integration Act* do not preclude the advancement of health equity, health promotion and community development, the act should be

strengthened to explicitly mandate these principles. An important next step will be to require LHINs to engage in a health equity assessment for all major planning and funding decisions. This health equity assessment must include direct consultation with those who utilize health services and, in particular, those who face the greatest barriers in accessing these services.

Recommendation #12: Amend the Local Health System Integration Act to make health promotion, community development, and health equity expectations of the LHINs. Require LHINs to engage in a health equity assessment for all planning and funding decisions.

b) Health Human Resources

Health human resources are the fuel necessary to drive the engine of change in Ontario's health system. However, RNAO is stunned to see such little attention being placed on health human resource planning. Despite several key reports being released by government in the past 12 months, there has been no presentation of a substantive health human resource plan for the province.[xxix] Ontario is in urgent need of an interprofessional health human resource plan that incorporates: government priorities for the system; population health needs; and full/expanded scope utilization of a range of health providers. There is a sense of urgency, given that an unfortunate and alarming phenomenon has re-surfaced in some parts of Ontario: RNs are being replaced with less qualified providers, and organizations are fragmenting organizational models of nursing care delivery into tasks delegated to practical nurses and unregulated providers, greatly compromising nursing care and patient outcomes.[xxx] These concerning activities are motivated by short-sighted attempts to control local health-care spending. But history clearly tells us that they cost the system much more in the long run, while unnecessarily putting Ontarians' health at risk. This has led more than 17,000 respondents, of which over 2,100 are members of the public, to answer an urgent call issued by RNAO urging Minister Hoskins to stop the replacement of RNs with less qualified providers. RNAO reaffirms this call and urges the Minister to issue a moratorium on the replacement of RNs with less qualified providers, pending the development of a comprehensive interprofessional health human resource plan. Regardless of this plan, RNAO calls on the Ministry to put a stop to fragmented organizational models of nursing care delivery, because the evidence is conclusive that they disrupt continuity of care and continuity of caregiver, which in turns compromises safety and quality of patient's outcomes. To this end, RNAO is preparing a report to be issued in Spring 2016 that will provide a comprehensive analysis regarding nursing human resource distribution and organizational models of nursing care delivery.

To promote workforce stability in the primary care sector, RNAO urges Minister Hoskins to move swiftly with the allocation of $85M in the 2016 provincial budget to substantively increase primary care NPs' compensation to remedy significant compensation inequities.[xxxi]

Recommendation #13: Develop an interprofessional health human resource plan to align population health needs and the full (and where appropriate, expanded) scope of practice of all regulated health professionals with system priorities. In the meantime, issue an immediate moratorium on the replacement of RNs with less qualified providers.

Recommendation #14: Put a stop to fragmented organizational models of nursing care delivery and support primary nursing models that enable total patient care.

Recommendation #15: Bridge compensation gaps that exist for primary care NPs through the roll out of the $85M committed to in the 2016 provincial budget.

c) Stewardship Role

In the Auditor General of Ontario's review of the LHINs in 2015, she reported that "due to inconsistent and variable practices that still persist across the province, patients face inequities in accessing certain health services."[xxxii] Minister Hoskins' proposal expands the role of the LHIN. This is welcomed. However, it is important that the Ministry strengthens its role as steward of the entire health system. This role involves monitoring whole system performance. For this, the Ministry can be aided by health system evaluations with set outcome indicators, collected and reported by Health Quality Ontario and ICES (depending on the type of indicators). This role is also meant to ensure that LHINs engage in a consistent population health planning approach across the province. This does not take away from the LHIN's autonomy to respond to the local context, however, it aims to enforce consistent standards across all LHINs that advance equitable access to health services in the province.

Recommendation #16: Strengthen the Ministry's role as a steward of Ontario's health system through the adoption of consistent planning standards across the province.

d) Interprofessional Care and Leadership

A key pillar for success of the Minister's vision will be expanding access to interprofessional care. It is concerning to see reference in the discussion paper to: "... improving access to interprofessional teams for those who need it most." RNAO encourages the Ministry to identify a short, medium, and long-term vision for delivering and expanding interprofessional primary care in the province. We believe that all Ontarians would benefit from, and deserve, access to interprofessional care. We recognize that the intensity of interprofessional care will vary based on a person's individual care needs. It is unclear to us why the Minister's vision suggests interprofessional care should be rationed for "those who need it the most." Rationing access to interprofessional health care only perpetuates downstream illness-based care. All Ontarians should be able to benefit from health promotion and early intervention through the proactive monitoring and early intervention capacity of teams. Failure to do so creates a revolving door, whereby those who have not benefited from interprofessional care, particularly those who could be considered on the 'border' of complexity, will require more intensive intervention from falling through the cracks. It also limits our capacity to delay the onset of chronic illness, which is costly to individuals in human terms, and also fiscally to the health system.

It is encouraging to see the paper identify gaps in service for those with mental health and addiction challenges. These are very real concerns as the prevalence is high and many Ontarians struggle to access service. A comprehensive framework is needed to improve access to care in the province. Specific

attention should be given to the role of primary care in collaboration with community mental health agencies. One way of improving the capacity of primary care to effectively respond to mental health and addictions challenges is through comprehensive interprofessional practice.

Expanding access to interprofessional care does not necessarily require significant investments. One method to do so is by following through on the government's commitment to expand the scope of the RN to include prescribing. This will improve system-wide capacity, including that of primary care, to deliver expanded hours of service and same-day care. It will also improve access to proactive care and treatments that will prevent complications from delayed intervention. RNAO is advocating for an *independent RN prescribing* model through an enabling legislated/regulatory framework that supports the diversity of settings in which Ontario's 96,000+ RNs practise. Supplemental and protocol-based models reinforce the status-quo through medical directives and produce minimal impact on access. It is worthwhile noting that RNs deliver care to many populations that experience some of the greatest difficulties accessing appropriate and comprehensive health services, such as: First Nations, Métis and Inuit Peoples, newcomers and refugees, LGBTQ persons, Franco-Ontarians, and persons experiencing homelessness. Delivering care to these groups and others demands an independent prescribing model. RNAO is also recommending that the scope of the RN be expanded to include the ability to order diagnostic testing and communicate a diagnosis. Doing so will enable RNs to offer continuity of care and continuity of care provider, instead of having to parcel out care for scenarios that are well within the RN's scope of practice (e.g. uncomplicated infections, hydration issues, etc).

RNAO also wants to bring attention to outstanding scope of practice barriers for NPs that ought to be remedied immediately to enable person-centred care. Necessary regulatory changes are urgently needed to authorize NPs to prescribe controlled substances, including methadone and suboxone (harm reduction) and testosterone (support transgendered persons).[xxxiii] RNAO is also urging the government to lift restrictions that currently prevent NPs from ordering all x-rays and CT/MRI scans.[xxxiv] Lastly, amendments are immediately needed to the *Mental Health Act* to authorize NPs to initiate an application for psychiatric assessment when a person is at risk of harming themselves or others and is suffering from mental/emotional distress.[xxxv] The growth of the NP role in Ontario's health system, including serving as the lead primary care provider for thousands of Ontarians and most responsible provider (MRP) in hospitals, demands prompt resolution of these gaps to ensure NPs can continue to deliver safe, timely and effective care.

Recommendation #17: Identify a short, medium, and long-term vision for delivering and expanding interprofessional primary care in the province. Critical enablers include:

- *Adopting an independent model of RN prescribing, coupled with the authority to order diagnostic testing and communicate a diagnosis.*
- *Remedying outstanding scope of practice issues for NPs.*

e) Evidence-based practice

Launched in 1999, RNAO has developed a comprehensive program, through its *International Affairs and Best Practice Guideline (IABPG) Centre* that focuses on transforming nursing practice through the use of

evidence. RNAO, in collaboration with the Ministry of Health and Long-Term Care as a funding partner, has become a world leader in the development, dissemination, and support for active implementation and evaluation of evidence-based best practice guidelines (BPG). In 2013, RNAO was designated as one of only 12 *Research and Development Centres* by the International Council of Nurses (ICN).[xxxvi] There are currently 52 clinical and healthy work environment guidelines in publication.[xxxvii] This work is complemented by several impactful initiatives:

1) Best Practice Spotlight Organizations (BPSO).[xxxviii] First launched in 2003, the BPSO initiative is an offshoot of the RNAO's BPG program and has since spread across Canada and to countries around the world. BPSOs are health and academic organizations selected by RNAO through a request for proposals process to systematically implement and evaluate BPGs. The program provides support to organizations that have formally agreed to implement and evaluate multiple guidelines over a three-year period. There are currently 94 BPSOs representing over 500 health organizations around the world - with about 75 per cent in Ontario.
2) Nursing Order Sets.[xxxix] RNAO's nursing order sets facilitates translating evidence into nursing practice by providing clear, concise, actionable evidence-based intervention statements that are readily incorporated into various practice settings. They are designed to be integrated into an electronic health or medical record, and they may also be used in a paper-based or hybrid order-entry system. The order sets aim to transform nursing and interprofessional practice by leveraging technology to promote knowledge translation and evidence-based decision making.
3) NQUiRE.[xl] (*Nursing Quality Indicators for Reporting and Evaluation).* This is a data system of quality indicators designed for BPSOs to monitor the progress and evaluate the outcomes of implementing RNAO's BPGs in their organizations. NQuIRE is the first international quality improvement initiative of its kind, and involves development and measurement of structural, process and outcome indicators related to each of the RNAO best practice guidelines and its impact on patients, health organizations and health systems.

The positive impact of evidence-based nursing practice on clinical outcomes is well documented, and there is a growing body of research that demonstrates a relationship between nursing care and patient/resident outcomes such as functional status, symptom control, falls, pressure ulcers, self-care, health-care utilization and mortality.[xli] For example, a study conducted at a tertiary care Ontario hospital reported a 20 per cent reduction in the annual fall rate after the comprehensive implementation of RNAO's falls prevention BPG.[xlii] Other research has shown that nursing practice based on recommendations in RNAO's BPGs resulted in improvements in over 50 per cent of indicators in both hospital and community settings related to asthma, diabetic foot ulcers, and venous leg ulcers.[xliii] We know that evidence-based practice improves the ability of clinicians to deliver safe and quality care. This, in turn, drives improved patient outcomes and health system effectiveness. Therefore, RNAO calls on the Ministry of Health and Long-Term Care to enable supportive environments and resources that promote evidence-based practice as the norm.

Recommendation #18: Enable supportive environments and resources that promote evidence-based practice as the norm.

f) Evaluation

As the Minister moves forward with the proposals, it will be important to evaluate both the process used and the outcomes. Evaluation data should include impacts on patient/provider experience and satisfaction, patient outcomes, and health system health outcomes as well as expenditures. Moreover, as the process unfolds, it is important to have a clear vision for where the system is moving, while embracing a fluid process that can be adapted as necessary.

Recommendation #19: Evaluate the process and outcomes of health system transformation efforts at the patient, provider and system level.

Conclusion

Ontario's health system belongs to its people. As the chief steward, the Minister of Health and Long-Term Care has an important leadership role to play in ensuring that the system effectively meets the needs of the population as patients and citizens. We commend the Minister for advancing proposals that have been informed by our ideas and are stimulating great discussion across the province. The time has come for bold change. RNAO reiterates its gratitude for the opportunity to respond to the consultation underway and we urge the Minister to carefully review our feedback. We hope to see it reflected in the next steps of this important work.

A final message to our Minister: be bold and visionary. The type of health system restructuring being proposed is likely to come once in a generation. Thus, move forward with health system and human resource restructuring that will lead to real change that delivers faster and better access, improves the health experience and outcomes for all Ontarians, and results in a higher performing and more cost-effective health system. Ontarians deserve nothing less.

Appendix A:

Sample Primary Care Co-ordinator Role Description

Position Overview

The Primary Care Co-ordinator (PCC) works within a primary care setting to engage medically and socially complex patients, and those at risk of developing complex needs, in establishing a co-ordinated care plan (CCP). The PCC identifies and integrates socio-economic barriers and upstream health promotion and prevention services to address health inequities and improve the patient's experience through an integrated system of care. The PCC advocates on behalf of the patient and/or family for care closer to home. The PCC shall provide leadership focused on quality, safety, strengthening access, co-ordination, continuity and transitions of care.

As the primary point of contact for the patient and/or family, the PCC, with the patient and/or family, establishes an electronic CCP, identifies the care team, and integrates services across the continuum. The PCC monitors and evaluates shared-care services from other providers according to the patient's goals and expected outcomes.

The PCC is an adaptive leader who influences relationships between the patient, family, and care team based on the common principles of trust, which are established through co-operation, co-ordination, and collaboration on shared goals and objectives that are focused on improving outcomes of care and the patient's experience through care transitions.

Qualifications

- Registered Nurse
- Knowledge and skill around medical and social needs; health assessment and nursing interventions
- Ability to engage with people and advocate for patients through effective communication
- Awareness of the structure of the health system to provide patient navigation
- Thrives in a team-based environment, while embracing an autonomous practice
- Empathetic approach to patient care
- Capacity to manage a busy caseload with multiple priorities
- Ability to engage in evidence-based practice and apply clinical practice guidelines
- Leadership skills, including group facilitation and conflict management
- Comfort and/or willingness to embrace technology enabled solutions
- Current member of the Registered Nurses' Association of Ontario (RNAO) preferred
- Valid driver's license, vehicle and insurance required

Responsibilities

a. Establish Plan of Care

- Pre Assessment: Reviews the current primary care medical record. Identifies, reviews and considers current assessments conducted by other members of the care team and broader sector partners to prevent duplication
- Meets with patient's care team to identify opportunities for optimizing health outcomes.

b. Engagement

- ❖ Arranges for a home visit to meet with patient and/or family
- ❖ Educates patient and/or family on privacy and consent
- ❖ Engages patient and/or family in establishing the patient's goals through the patient's CCP.
- ❖ Establishes patient's care team i.e. primary care provider, PCC, home health-care and support services
- ❖ Empowers the patient to be active in their plan of care and expected outcomes
- ❖ Completes a clinical nursing assessment
- ❖ Completes a medication review and reconciliation, referring to a physician, nurse practitioner or pharmacist as required
- ❖ Identifies socio-economic barriers influencing the social determinants of health
- ❖ Assesses for patient safety and mitigates risks within the CCP
- ❖ Integrates the patient's social support network into the CCP
- ❖ Promotes self-management through education and service options
- ❖ Integrates upstream health promotion and prevention strategies into the CCP

c. Co-ordinated Care Planning

- ❖ Establishes and maintains the CCP through an electronic platform.
- ❖ Acts as a liaison and single point of contact for the patient, family and the patient's care team
- ❖ Co-ordinates and supports the patient in navigating the health and social services to deliver the plan of care across the continuum (from birth to death)
- ❖ Advocates on behalf of the patient and family
- ❖ Identifies and arranges for the right service, at the right time between service organizations, including the initiation of home health-care and support services
- ❖ Delivers direct clinical services when needed
- ❖ Facilitates referrals to services and programs and follows up with referrals to ensure seamless transitions in care
- ❖ Monitors and adjusts service provision based on expected outcomes
- ❖ Monitors and evaluates patient's CCP and evaluates the patient's attainment of goals
- ❖ Builds positive working relationships with organizations and their staff to support the patient's CCP and to attain seamless transitions in care
- ❖ Supports the patient's care team in viewing and updating the patient's electronic CCP
- ❖ Ensures for timely collection and reporting on changes to the patient's CCP the care team i.e. status of patient's plan of care between primary care and sector organizations, changes to services, specialist updates, diagnostics
- ❖ Conducts regular reassessments of patients based on changes to patient's health and goals

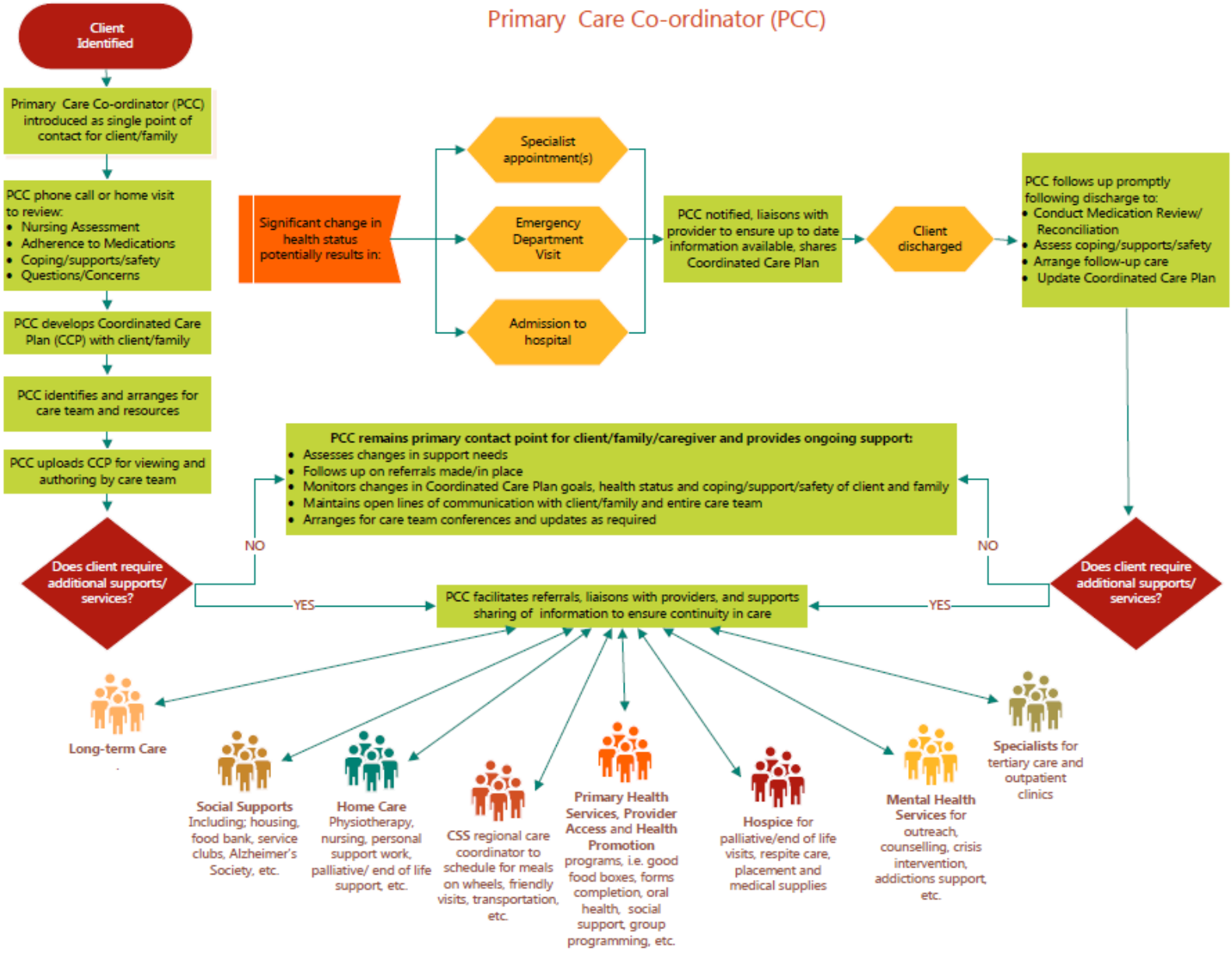
d. Performance Outcomes

- ❖ Provides monthly and quarterly reporting on established performance metrics
- ❖ Evaluates patient and provider satisfaction i.e. satisfaction surveys, patient engagement forums, patient stories
- ❖ Monitors for breach of privacy in the electronic Coordinated Care Tool platform

In addition to the specific key job responsibilities identified, the Registered Nurse Care Coordinator is committed to organizational responsibilities:

1. Works in a manner that preserves confidentiality.
2. Works in a manner that seeks to minimize risk to patients, the organization, and to staff through a commitment to quality and safety.
3. Fully participates in evolving goals of e-health strategies and commits to best practice in information technology and management.
4. Communicates in a timely and positive manner regarding job content, specific objectives and personal performance. Identifies performance goals, objectives and learning needs. Identifies concerns in a timely manner and in collaboration with manager to seek resolution.
5. Incorporates critical thinking practice and a collaborative approach to problem solving and decision-making.
6. Contributes to the overall mission of the organization by participating in meetings and on committees as required to identify, respond and/or resolve issues or opportunities for improvement.
7. Incorporates and contributes to the organizations efforts for continuous improvement by identifying, implementing and evaluating policies and practices to support best practice.
8. Integrates into work functions the principles of respect and value for staff, patients, and the community.

Sample Primary Care Co-ordinator (PCC) Process Map



Case Load For Care Co-ordinators

All Ontarians can benefit from care co-ordination. However, the level and extent differs over the course of the patient's journey through the health system. There is a need to align finite resources with need, however, resources should not be focused exclusively on those with complex needs, but rather to consider this group in parallel with others who are at risk of becoming more complex. Below are some guiding principles to inform a case load for PCCs.

- Health system navigation is linked with care co-ordination.
    - However, some Ontarians may need navigation support, while others may need navigation and care co-ordination services.
- Provincial standards for care co-ordination and health system navigation should be developed.
- A provincial/consistent approach should be developed to support primary care organizations in determining case loads.
    - A risk-adjusted scoring system, based on medical and social complexity, could be developed (or adapted) based on factors identified by the King's Fund.
- Majority of CCAC care co-ordinators are RNs (over 3,000).
- Recommend a case load of no more than 60 clients per RN. However, this will vary.
    - RN care co-ordinator key point of contact for patient
    - Case load should be divided between complex clients and those at risk. (i.e. 15 complex clients and 45 clients at risk of becoming complex)
    - Other providers (i.e. social workers) have more focused role and potentially higher caseloads (see the Gundersen Lutheran Health System Care Co-ordination model). For example, social workers focus on assessing financial and social needs and assisting patients in obtaining resources.
- Designate a clinical lead within the primary care organization (or sub-LHIN region) who can monitor case loads and scoring.
- Utilize existing primary care RNs and other qualified providers to co-ordinate care for the balance of the population.
- Clinical resources and supports should be developed to enable care co-ordination vs. case management.

Manageable caseload – *Adopted from the King's Fund – Case Management*
http://www.kingsfund.org.uk/sites/files/kf/Case-Management-paper-The-Kings-Fund-Paper-November-2011_0.pdf

There is no consensus over what is an appropriate caseload for a case manager. Department of Health guidance suggests that community matrons are likely to have caseloads of between 50 and 80 patients requiring clinical intervention and care coordination (Department of Health 2005). This guidance also suggests that more than 80 patients would make a clinician's caseload 'unsustainable' (p 39).
...

Some studies have explored issues relating to size of caseload (Boaden et al 2006; Sargent et al 2008; Russell et al 2009). They show that the number of patients deemed to be manageable in a caseload is influenced by various factors, including:

- the nature of patients' conditions
- the proportion of patients at high risk (it has been suggested that high-risk patients should not exceed 10–15 per cent of the caseload– see Sargent et al 2008)
- the experience of APNs/community matrons in working with patients with complex needs
- patients' socio-demographic profiles
- patients' circumstances (specifically home environment and access to informal care support)
- patients' geographical location (urban or rural settings)
- patients' individual characteristics (for example, willingness to engage with community matrons)
- time needed for non-clinical activities.

The Evercare evaluation showed that caseloads of approximately 50 patients were deemed to be the 'upper manageable limit' (Boaden et al 2006, p 66). If a caseload becomes unmanageable, case managers are at risk of providing a reactive service that largely responds to crises rather than providing the proactive and preventive service intended (Sargent et al 2008; Russell et al 2009). Case managers with caseloads in excess of 50 have reported work-related stress (Sargent et al 2008). Research on ideal caseload size has been carried out only from case managers' perspectives so far. Therefore it is difficult to appraise this from the perspective of patients and their carers, or commissioners.

Case Load Comparisons Matrix

Model	Target	Caseload
CCAC (varies across each CCAC)	Focus on the management of home health-care, palliative and support services.	Caseload is determined in one CCAC through CHRIS, using a points system (SRC Coding and Risk Code) Acute vs. Chronic clients -Rehab -Maintenance -Long-Term Supportive -End-of-Life Team leaders review scores weekly.
Gundersen Lutheran Health System Care Co-ordination model http://www.nursingworld.org/carecoordinationwhitepaper	Effort to reduce re-hospitalizations by identifying the sickest 1-2% of the system's patient population and providing care coordination services in an integrated model	40-60 patients for each RN 70-100 patients for each Social Worker The RN maintains contact with the patient and other members of the health care team; the

Model	Target	Caseload
		participant's care is managed in the ambulatory setting as much as possible. The social worker partners with the RN to assess financial, social, and emotional needs and assist patients in obtaining the resources they need to manage their care at home.
Guided Care http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3042340/ https://innovations.ahrq.gov/events/2010/06/realizing-benefits-guided-care-nursing	A registered nurse works in a practice with several primary care providers, conducting eight clinical processes for 50–60 multimorbid patients.	50-60 patients for each RN The case load of 50-60 patients per RN was determined by surveying other similar intensive care management programs, such as those that served renal dialysis patients and HIV/AIDS patients
ProvenHealth Navigator http://ccmcertification.org/sites/default/files/downloads/2012/40%20-%20IB%20Team-based%20chronic%20care%20management-%20guided%20care%20and%20Provenhealth%20navigator%C2%AE%20offer%20models%20of%20interdisciplinary%20team-based%20care.pdf http://ccmcertification.org/sites/default/files/downloads/2012/40%20-%20IB%20Team-based%20chronic%20care%20management-%20guided%20care%20and%20Provenhealth%20navigator%C2%AE%20offer%20models%20of%20interdisciplinary%20team-based%20care.pdf	Addresses the needs of chronically ill patients with complex multiple morbid conditions.	125-150 patients per RN

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