



**Submission to the Government of Ontario's Seniors  
Care Strategy**

**Registered Nurses' Association of Ontario (RNAO)**

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## Executive Summary

The Registered Nurses' Association of Ontario (RNAO) welcomes the government's decision to develop a Seniors' Care Strategy, as Ontario's nurses have long advocated to ensure that every senior in Ontario has the opportunity to live in dignity as a respected and independent member of the community.

RNAO calls on government to implement a Seniors' Care Strategy that increases access to home care and support services to benefit seniors; most of whom would rather stay in their homes than be institutionalized. Moreover, RNAO urges that a broad focus be used to reinforce the underlying concepts embodied in the five identified priorities by government to maximize their impact. The focus on "doctors' house calls", should be reconsidered to embrace the desired outcome of 24/7 access to primary care for Ontario's seniors, where house calls are more appropriately and efficiently led by primary care Registered Nurses (RNs) and Nurse Practitioners (NPs) in collaboration with physicians and other members of the interprofessional team. Furthermore, simply encouraging seniors to eat well and exercise regularly will produce very little impact unless government addresses the overriding effects of social and environmental determinants of health and the day-to-day reality that many older persons live in poverty. Nurses know that "blaming the victim" policies are not only ineffective but also damage self-efficacy, resilience, and the sense of connectedness we all need with the broader community to experience social inclusion – a pivotal social determinant of health. Based on substantive evidence, RNAO cannot endorse a strategy that wrongly assumes every senior has equal access to nutritious food or the ability to access physical activity supports.

RNAO calls on government to take a comprehensive approach in developing an evidence-based and integrated Seniors' Care Strategy with the goal of improved mental, physical and social health outcomes, while leveraging existing resources, minimizing structural duplication and upholding a stronger publicly-funded, not-for-profit health system. Such a strategy needs to align with the following principles: Senior-centredness; integration and co-ordination across the health system; a strengthened publicly-funded and not-for profit health system; focus on health and wellness; social, environmental, economic and indigenous determinants of health; driven by evidence and best practices; equity and access to services; dignity, respect, independence and self-determination; cost-effective and appropriately resourced; and community and family orientation. These principles must inform a combination of system-level and multi-sectoral recommendations that prompt action from government to produce a Seniors' Care Strategy that maximizes health outcomes and health system cost-effectiveness.

RNAO, like many other organizations within the health system, is ready and eager to work with government to implement cost-neutral solutions that leverage the potential that already exists within the system. For example, full implementation of RNAO's ground-breaking provincial task force report, *Primary Solutions for Primary Care*<sup>1</sup> will ensure the full scope of practice utilization of RNs and RPNs in all primary care settings and significantly improve the capacity of Ontario's primary care sector to meet the complex needs of an aging population. Utilizing the competencies, knowledge and skills of primary care RNs already in the system and maximizing/expanding inter-professional primary care models will result in cost-effective care co-ordination and improved health system navigation for Ontario's seniors.

Similarly, reducing role duplication by adopting RNAO's *Enhancing Community Care for Ontarians* (ECCO) model and transitioning the roles and functions of Community Care Access Centres (CCACs) to existing structures, such as LHINs, primary care, home health care, and hospital discharge planning, would advance system cost-effectiveness, while enhancing care co-ordination, system navigation, same day access to primary care and expanded home care services. This model offers comprehensive and continuous RN-led care co-ordination across the lifespan to all Ontarians and especially to those in greatest need, such as seniors living with complex chronic illness. Effective care co-ordination within primary care will support seniors' independence within the community by ensuring that the appropriate resources and supports are there at all times. If the time comes that living at home necessitates assistance, the ECCO model facilitates co-ordination of home health care services and when living at home is no longer possible, the ECCO model facilitates long-term care (LTC) placement in a way that increases efficiency and continuity while improving both resident and system-level outcomes.

The government's priority for evidence-based policies and practices, is also a long standing focus of RNAO -- since its renowned Best Practice Guideline program was created in 1998. The positive outcomes, at the patient, organizational and system levels are substantive. There is no question that the care provided to seniors across the health system must be aligned with best available evidence, and embedding RNAO's rigorously developed and effective Best Practice Guidelines as the cornerstone of an evidence-based Seniors' Care Strategy, is imperative if Ontario is to optimize results for its seniors. Examples of the impact of RNAO's evidence-based work include the Falls Prevention Program for LTC in partnership with the Canadian Patient Safety Institute (CPSI), RNAO's Prevention of Elder Abuse Program, and the widespread implementation of RNAO's Clinical BPGs relevant to the other adult, such as: *Client Centred Care; Assessment and Management of Pain; Assessment and Management of Stage I – V pressure ulcers; Caregiving Strategies for Older Adults with Delirium, Dementia and Depression; Collaborative practice among nursing teams; Developing and sustaining nursing leadership; End of life care during the last days and hours; Oral health nursing assessment and intervention; Preventing and managing violence in the workplace; Prevention of Constipation in the older adult; Prevention of falls and fall injuries in the older adult; Promoting continence using prompted voiding; Promoting safety: Alternative approaches to the use of restraints; Risk assessment and prevention of pressure ulcers; Screening for delirium, dementia and depression in the older adult.*

The solutions offered in this submission will significantly strengthen the development of a comprehensive and impactful Seniors' Care Strategy that nurses can fully support and lead, and RNAO is eager and ready to work with government to make it a reality.



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

## **Registered Nurses' Association of Ontario (RNAO) Submission to the Government of Ontario on the Seniors' Care Strategy**

### **Introduction**

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses (RNs), in all settings and roles across Ontario. It is the strong, credible voice leading the nursing profession to influence and promote healthy public policy. RNAO is proud of its long history of advocating with government and others to improve seniors' health through a comprehensive and integrated strategy. RNAO welcomes the opportunity to influence and shape Ontario's Provincial Seniors' Care Strategy.

Starting with the Government's Action Plan for Health Care<sup>2</sup> the proposed strategy aims to ensure seniors have access to the right care at the right time and in the right place. Specifically, the strategy aims to deliver the following: (1) expanding doctors' house calls; (2) increasing access to home care for seniors in need; (3) establishing care co-ordinators to work with health providers to ensure seniors receive the right care, particularly following hospitalization; (4) creating a Healthy Homes Renovation Tax Credit to help seniors adapt their homes to meet their changing needs; and, (5) helping seniors stay healthy by eating well and exercising regularly.<sup>3</sup>

RNAO goes on record that these five deliverables fall short of a Seniors' Care Strategy worthy of Ontarians' respect. RNAO recommends that a comprehensive and integrated seniors' strategy be based on principles that strengthen a publicly-funded and not-for-profit health system; advance evidence-based practice, and reduce structural duplication that hamper system integration and access to care for older persons. These principles guide RNAO's recommendations aimed at producing optimal results for government, tax payers, and most importantly Ontario's seniors.

Throughout this submission, reference is made to the *Enhancing Community Care for Ontarians* (ECCO) model (Appendix A) that RNAO is leading in consultation with a wide range of stakeholders across the health system. In broad terms, ECCO involves transitioning the current functions of Community Care Access Centres (CCACs) to existing structures over a three year period. These structures include: LHINs, public health, primary care, hospitals, home care/support organizations, and long-term care. It is proposed that this transition be supported by a temporary Primary Care Secretariat within the LHIN structure as the capacity of interprofessional primary care models are simultaneously strengthened to embrace its new and expanded role. This unique model leverages the strength of RN Care Coordinators in primary care to assist seniors in navigating the sometimes daunting complexities of the health system, while also coordinating care needs across multiple providers. ECCO's evidence-informed model aligns closely with the requirements for a principled, comprehensive and integrated Seniors' Care Strategy that focuses on improving health outcomes and strengthening Ontario's publicly-funded and not-for-profit health system.

**Recommendation 1: Ontario’s Seniors Care Strategy should be principled, comprehensive, integrated and aligned with best evidence, improved health outcomes and a strengthened publicly-funded, not-for-profit health-care system.**

### **Principles of a Seniors Care Strategy**

In 1998, RNAO invited the Ontario’s Senior Citizens Coalition and the Older Women’s Network to form the Elder Health and Elder Care Coalition. By 2000, 30 umbrella organizations had joined the Coalition representing associations and providers eager to strengthen health and wellness services for Ontario’s older persons. Renamed as the Elder Health Coalition (EHC), this powerful body joined forces with the Ministry of Health and Long-Term Care (MOHLTC) in a yearly Think Tank that jointly developed a shared vision of a vibrant future for Ontario’s seniors. In 2003, the success of the EHC was noted when it became an advisory to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors.<sup>4</sup> In 2005, the Elder Health Coalition Framework, was developed based on the inherent values of aging in place and choice for older persons through early intervention and prevention services. In keeping with this framework, a Seniors’ Care Strategy in Ontario must build on the view that seniors are a resource to their families, communities and economies and support overall community health.<sup>5</sup>

RNAO is eager to build on its earlier collaborative work to communicate the essential elements of a comprehensive and integrated provincial Seniors’ Care Strategy. The starting point is acknowledging that seniors are entitled to a quality of life that supports their optimal health. This understanding is supported by the philosophy of active aging, which values and promotes the contribution of older persons to vibrant life of all healthy communities.<sup>6</sup>

Building on the EHC work, RNAO supports the following principles for a comprehensive and integrated Seniors’ Care Strategy in Ontario:

1. Senior-centredness
2. Integration and co-ordination across the health system
3. A strengthened publicly-funded and not-for profit health system
4. Focus on health and wellness
5. Social, environmental, economic and indigenous determinants of health
6. Driven by evidence and best practices
7. Equity and access to services
8. Dignity, respect, independence and self-determination
9. Cost-effective and appropriately resourced
10. Community and family oriented

**Recommendation 2: Ontario’s Seniors Care Strategy be based on the above ten principles.**

## **Myth of Medicare Being Unsustainable Because of Aging Population**

Many writers begin their inquiry into seniors' health by incorrectly attributing the so-called unsustainable health system to an aging population. As Robert G. Evans and others point out: "Medicare is as sustainable as Canadians want it to be."<sup>7 8 9</sup> In fact, an aging population only accounts for a minor proportion of rising expenditures. Spending on Medicare – hospitals and physicians' services – has stabilized at four to five per cent of the gross domestic product (GDP) since 1975, but the cost of health services not covered by Medicare, such as drugs, dentistry and other non-Medicare treatments has risen from three per cent of the GDP to seven per cent in 2009. Evans attributes these costs as driving up health-care spending in recent years. In fact, according to recent OECD reports, the public share of Canada's overall health costs – 70 per cent -- is a relatively low for a high-income OECD country<sup>10</sup>

Evans' view is echoed by the Canadian Health Coalition who point to the fact that population aging is only increasing health-care costs by 0.8 per cent per year, which is less than both population growth (one per cent) and inflation (2.5 per cent). Other factors that drive up health-care costs include the increased use of prescription drugs, medical imaging and other expensive medical technology.<sup>11</sup>

Medicare is not only as sustainable as Canadians want it to be, but it is also as comprehensive as we want it to be. Tommy Douglas' vision of Medicare was to cover drugs, dentistry, vision, home care and most other health services.<sup>12</sup> More importantly, Douglas foresaw a second phase of Medicare that focused on disease prevention and confronted social and environmental determinants of health that make people unwell in the first place.<sup>13</sup>

In outlining a comprehensive and integrated seniors' care strategy, RNAO takes up the challenge from Evans and Douglas. To paraphrase Evans, a seniors' care strategy is as sustainable and comprehensive as we want it to be. RNAO proposes a strategy that explodes the myth of seniors being responsible for the 'inability to sustain' Medicare by demonstrating that the well-being of seniors goes hand-in-hand with identifying cost efficiencies and strengthening Medicare.

## **By the Numbers**

Recently, the Canadian Nurses Association (C.N.A.) issued a report entitled *A Nursing Call to Action* that reminded us aging is a phase of life, not a disease. Most seniors in Canada feel their health is generally good and more than 90 per cent want to live at home for as long as possible.<sup>14</sup> However, the percentage of seniors with overall good health and independence drops sharply in older age categories, with per capita health spending totaling about \$8,425 at age 75 and \$16,821 by age 85. Currently, the fastest growing cohort of older persons – at about 1.2 million - is persons over 85 years of age.<sup>15</sup>

Many chronic diseases, including cancer, diabetes, hypertension and dementia, all show rising prevalence for those over age 65. About four in five seniors living at home have at least one diagnosed chronic condition compared to one in ten of those between the ages of 25 and 54.<sup>16</sup> In addition, the risk of falls among seniors increases considerably and approximately 40 per cent of admissions to long-term care homes are directly attributed to falls.<sup>17</sup> Moreover, threats to health are not just physical. Seniors can be vulnerable to social isolation and suicide with ten to 15 per cent suffering from depressive symptoms or clinical depression. Evidence also clearly suggests seniors are highly vulnerable to abuse.<sup>18 19</sup>

Policies must reflect the changing demographics and ensure equitable access to care. A Seniors' Care Strategy must pay greater attention to disease prevention and health promotion to keep our seniors as healthy and independent as possible, while delaying chronic disease and reducing disability. Resources must be accessible and affordable in homes and communities, with support available for family and caregivers.

### **Social and Environmental Determinants of Health**

As is clear from the proposed principles that for nurses, Ontario's Seniors' Care Strategy, must acknowledge the broad determinants of health. As pointed in the EHC Framework: "It is only possible to address the needs of older persons when basic necessities such as adequate income, acceptable housing, a safe environment and access to proper nutrition are provided. The determinants of health support optimum elder health."<sup>20</sup>

In its Nursing Call to Action, C.N.A refers to social and environmental determinants of health consisting of such factors as: income, social support, level of education, security of housing and food, literacy, employment, working conditions and gender. Each factor means some people are at increased risk for health complications.<sup>21</sup>

As the recent POWER (**P**roject for an **O**ntario **W**omen's **H**ealth **E**vidence-Based **R**eport) study affirms, those with lower socioeconomic status have a disproportionately high rate of poor health, chronic conditions, co-morbidity and mortality. Women aged 65 and older with low incomes were found to have the highest burden of illness.<sup>22</sup> Nearly one in five older persons lives near the poverty line.<sup>23</sup> About 70 per cent of seniors' income comes from fixed sources and for many older people the cost of day-to-day living can be a challenge. Most susceptible to living in poverty are those seniors who live alone, women (especially those over 80), visible minorities and immigrants. Poverty impacts the ability of seniors to pay for a nutritious diet, decent housing and necessary medication. It can also keep them from accessing required support services and care.<sup>24</sup> As the Canadian Home Care Association notes, vulnerable individuals have a greater chance of 'falling through the cracks' or suffering unnecessary or premature institutionalization.<sup>25</sup>

RNAO strongly urges the government to fully incorporate social and environmental determinants of health when developing, implementing and evaluating Ontario's Seniors' Care Strategy. One example is the Ministry's stated intention to help seniors eat well and exercise regularly as an integral part of its Seniors' Care Strategy. A key consideration must be given to the many seniors living in poverty who do not have equitable access to nutritious food or exercise resources.

**Recommendation 3: Address social and environmental determinants of health in developing, implementing and evaluating the Seniors Care Strategy, with particular attention to income inequality as a key determinant of mental and physical health and life expectancy.**

### **Evidence-based Seniors Care**

For over a decade, RNAO's internationally renowned Best Practice Guideline Program, funded by MOHLTC, has rigorously developed, guided systemic implementation, and evaluated outcomes of clinical and healthy work environment guidelines to support quality, evidence-based decision making. In addition, RNAO has developed and refined a number of knowledge

exchange strategies that have been highly effective in using evidence to enhance clinical practice and management decision-making. Development and implementation of clinical practice guidelines in the area of elder care has been one of five top priorities of RNAO's Best Practice Guideline Program since inception. RNAO has supported the uptake of clinical practice guidelines<sup>26</sup> across the care continuum in a number of areas, including: falls prevention<sup>27</sup>; alternative approaches to the use of restraints<sup>28</sup>; continence<sup>29</sup> and constipation<sup>30</sup>; pressure ulcer prevention<sup>31</sup> and management<sup>32</sup>; delirium, depression and dementia<sup>33 34</sup>; pain management<sup>35</sup>; chronic disease management<sup>36</sup> and client centred care<sup>37</sup>. Organizations that are implementing these guidelines in the provision of health services to older adults are experiencing enhanced clinical, organizational and system outcomes.<sup>38 39 40</sup>

RNAO has augmented implementation activities through use of a very successful clinical guideline Champions Network wherein RNs, RPNs and Health Care Aides are supported to learn about evidence based practice and how to influence their peers in achieving quality care for their clients and residents.<sup>41</sup> In addition, RNAO has developed partnerships with hundreds of health-care sites by establishing the Best Practice Spotlight Organization Designation, enabling organizations to commit to creating an evidence based practice culture.<sup>42</sup> The results have been stunning, organizations providing health services to seniors that are implementing RNAO's guidelines are enhancing clinical and organizational outcomes, leading to improved system outcomes.<sup>43 44 45</sup>

RNAO has generated additional system-wide impacts in the care of older persons through provincial and national partnerships. For the past four years, RNAO has partnered with the Canadian Patient Safety Institute to lead over 100 long term care settings across Canada in a falls collaborative based on implementation and sustained use of the RNAO's Prevention of Falls and Injury from Falls Best Practice Guideline. System wide impacts generated include: consistent falls risk assessment practices; targeted falls prevention practices; and, reductions in falls and serious injury from falls from between 40- 80 per cent.<sup>46</sup>

RNAO is proud to be called on by Canada's premiers and territorial leaders through the Council of the Federation (CoF) to demonstrate how transforming our health system must be grounded in evidence. As a leading member of the clinical practice guidelines working group, along with the CNA and the Canadian Medical Association, RNAO's Guidelines for the Assessment and Management of Foot Ulcers for People with Diabetes was recommended for nation-wide adoption by the Council.<sup>47</sup>

The message being brought forward from the nation's leaders is clear, evidence-best practice and evidence-based decision making is integral to quality care in Canada and in RNAO's view, must be reflected in a provincial Seniors' Care Strategy. RNAO is a recognized international leader in this area and has produced a significant collection of guidelines, implementation supports and knowledge exchange strategies to support this process.

**Recommendation 4: Use RNAO's rigorously developed clinical practice and healthy work environment (HWE) guidelines as the cornerstone of an evidence-based seniors' strategy that enables clinical excellence within quality workplaces.**

**Recommendation 5: Adopt a cross sectoral evidence-based approach to policies and practices guiding Ontario’s Seniors Care Strategy, consistent with the Excellent Care For All Act (ECFAA).**

**Integrated Approach**

An important pillar of the Seniors’ Care Strategy is its integration with the broader health system. According to the Canadian Home Care Association (CHCA), integration must be built around the needs of people.<sup>48</sup> Successful integration reduces duplication and improves efficiency especially when meeting the care needs of seniors with multiple chronic conditions.<sup>49</sup> Integration of care allows specific skills and expertise to be leveraged at the right time and in the right place.<sup>50</sup> Integrated models of care are also critical for improving health outcomes and quality of life, and producing efficiencies within the system.<sup>51</sup> Adopting RNAO’s ECCO model across the province will provide the framework needed to strengthen integration across the health system, while promoting health system sustainability through the removal of duplication and inefficiency.

The Chief Medical Officer of Health of Ontario has called for the application of a “health lens to every program and policy” so that the health impacts and benefits of various decisions may be known.<sup>52 53</sup> Similarly, a seniors “health and well-being lens” should be applied to any government program or policy that affects the health and well-being of our seniors. The Chief Public Health Officer of Canada has emphasized the need to approach “problems from all sides with coordinated, multi-pronged, inter-sectoral action.”<sup>54</sup> In addition to monitoring progress and holding governments accountable for action on seniors’ care, it is also vital that seniors’ health impact assessments be used to better understand how all sectors – health, social, financial, international trade deals – affect the quality of life of seniors and their right to age in place with dignity.

**Recommendation 6: Introduce legislation requiring application of a seniors’ “health and well-being lens” to every government program and policy, as part of the Seniors’ Care Strategy to ensure effective implementation and evaluation.**

**Recommendation 7: The Seniors’ Care Strategy must be integrated with the broader health-care system, as reflected in RNAO’s ECCO model to meet the health needs of seniors.**

**Sectoral Contributions to a Seniors Care Strategy**

**Public Health**

Public health nurses play a key role in mobilizing their communities to: address social determinants of health, improve health and decrease health inequities by challenging ageist environmental and social policies. Public health is recognized as comprising five essential functions that each have an important impact on seniors’ health: population health assessment, health surveillance, health promotion, disease and injury prevention, and health protection.<sup>55</sup>

The Commission on the Reform of Ontario’s Public Services (Drummond Commission) initiated discussion on integrating Ontario’s 36 local public health units with other parts of the health system under the co-ordination of the Local Health Integration Networks (LHINs) while protecting the public health budget.<sup>56</sup> Public health should be integrated with other areas of the

health system to ensure that even the most vulnerable people, including many of our seniors, have access to a range of population-based promotion and preventative services.

**Recommendation 8: Ensure that the public health funding envelope is protected as public health is integrated into other parts of the health system including seniors' care, as recommended by the Drummond Commission.**

### **Primary Care**

Primary care is the vital foundation of a health system that is needed to generate optimal outcomes for seniors and to enable seniors to thrive as vibrant community members. An important strategic milestone on the path towards a Seniors' Care Strategy for Ontario was achieved when the RNAO released the ground-breaking provincial task force report *Primary Solutions for Primary Care*<sup>57</sup> on June 28, 2012. The report's recommendations (Appendix B) set out ambitious, but realistic, timelines to maximize and expand the role of Ontario's primary care nurses – both RNs and RPNs – by 2015.

A key finding of the report is that RNs and RPNs working in primary care, including Community Health Centres (CHCs), Nurse Practitioner-led Clinics (NPLCs), Aboriginal Health Access Centres (AHACs), Family Health Teams (FHTs), and physicians' offices, are not being utilized effectively and that there is an incredible amount of untapped potential.<sup>58</sup> Concluding that nurses can do more for their patients and make the health system more efficient, *Primary Solutions for Primary Care* puts in place an action plan that includes two critical phases: Phase one: Immediately maximize the scope of practice utilization for RNs and RPNs in primary care; and phase two: By 2015, expand RNs' scope of practice to include care co-ordination and RN prescribing. These two measures will go a long way to advance the government's goals of same-day access to quality primary care.

Interprofessional models of care delivery are producing the greatest value and effectiveness within Ontario's health system. Current interprofessional primary care organizations (i.e. CHCs, NPLCs AHACs and FHTs) must be expanded where infrastructure capacity exists, before creating new organizations. In alignment with the government's priority of interprofessional care delivery, a moratorium needs to be placed on the development of new solo practice models in Ontario. Additionally, mechanisms need to be in place to support current solo physicians to integrate within existing interprofessional primary care models. This approach is the most effective way to provide care for seniors who have care requirements demanding timely attention from primary care professionals.

Care co-ordination is essential to any comprehensive Seniors' Strategy. It was the unanimous view of an expert provincial task force that care coordination must function within Ontario's primary care setting.<sup>59</sup> Building upon this finding, RNAO's evidence-based ECCO model provides the framework needed to ensure that all of Ontarians, especially seniors, receive primary care-based coordination across the lifespan from 'womb to tomb'. This can be accomplished by transitioning the 3,000 RNs currently working in CCACs as case managers and care co-ordinators, to the primary care setting and maximizing their role in providing continuous care co-ordination to Ontario's most vulnerable populations - including seniors with highly complex care needs. The model also proposes that the 2,800 RNs that are already working in primary care co-ordinate care for seniors with relatively stable care requirements, to prevent

complications in the first place. This is all occurring within a system that is free from unnecessary duplication and inefficiency.

**Recommendation 9: Fully implement the recommendations of the RNAO's ground-breaking report *Primary Solutions for Primary Care* that would ensure maximum utilization of RNs and RPNs in all primary care settings.**

**Recommendation 10: Immediately expand staffing and capacity of existing nurse practitioner-led clinics (NPLCs), community health centres (CHCs), aboriginal health access centres (AHACs) and family health teams (FHTs) to fully maximize infrastructure utilization, while placing a moratorium on the creation of new solo practices in primary care. Create new NPLCs, CHCs AHACs and FHTs only in communities where there is no existing infrastructure.**

**Recommendation 11: Enhance health system effectiveness, primary care capacity including same day access, system co-ordination and navigation by maximizing and expanding the scope of practice of the 2,800 primary care RNs already within the system to serve as care co-ordinators for seniors with relatively stable care requirements.**

**Recommendation 12: Enhance health system effectiveness, including preventing hospital admissions, by transitioning the 3,000 RNs currently working in CCAC as Case Managers and Care Coordinators to primary care, and using their expertise for care coordination and system navigation of populations with complex care needs, including seniors with multiple co-morbidities.**

**Recommendation 13: Facilitate LTC home placement by Primary Care RN Co-ordinators to increase efficiency and continuity, and improve resident and system-level outcomes.**

## **Hospitals**

Hospitals continue to be a vital public resource for all Ontarians, including seniors, when they are very ill or injured. RNs must play an increasingly central role in acute care as part of the interprofessional team, practising at the bed-side to their full potential. Acute care facilities are strongly urged to fully embrace RNAO's Position Statement on Strengthening Client-Centred Care in Hospitals,<sup>60</sup> by basing their model of nursing care delivery on patient complexity, care needs and the degree to which patient outcomes are stable and predictable. Each patient is assigned one RN or RPN per shift, with RNs being assigned total patient care for complex or unstable patients with unpredictable outcomes and RPNs being assigned total patient care for stable patients with predictable outcomes. When unregulated staff such as personal support workers (PSWs) are utilized, they are assigned to assist RNs or RPNs where appropriate and under supervision. The focus is on supporting the continuity of care provided by the assigned primary nurse.

NPs, used to their maximum capacity in hospitals, can also greatly assist the objectives of a Seniors' Care Strategy. Amendments to *Regulation 965* of the *Public Hospitals Act*, 1990 showcase Ontario as the first jurisdiction in Canada to legally authorize NPs to admit, treat and discharge hospital in-patients. A two-stage process provided the legislated authority for NPs to discharge hospital in-patients effective July 1, 2011 while the authority for NPs to admit came into effect July 1, 2012. These amendments were made to improve patient flow and system

effectiveness in hospitals by providing equitable and timely access to care, particularly in underserved, rural and remote populations. Reduced wait times, improved patient safety and quality of care, improved patient satisfaction and reduced costs are expected outcomes of these changes.

**Recommendation 14: Focus should be on the right care, at the right time, in the right place, and by the right health professional, in alignment with RNAO's Position Statements on Strengthening Client-Centred Care.**

**Recommendation 15: Require all Ontario hospitals to act on expanded legislative authority to maximize their utilization of NPs to admit, treat, transfer and discharge patients and form strategic directions to expand NP roles and responsibilities to better address current and projected patient care needs. NPs have had the legislated authority to discharge since July 1, 2011 and admit since July 1, 2012.**

### **Home Care**

RNAO is committed to the fundamental principle that every Ontarian must be able to live in dignity as independently as desired and as a respected member of our community. In the short term this means enabling Ontarians to receive expanded health care services within the home from a patient-centered inter-professional team that includes nurse practitioners, clinical nurse specialists and other health professionals working to their full scope of practice, and community-based home support services.

CCACs were developed by the Ontario government in 1996 with the intention of bridging between hospital and home and help clients navigate the health system, but their budget has ballooned to about two billion dollars annually.<sup>61</sup> Moreover, CCACs were historically utilized by government as a venue to facilitate competitive bidding between home-care organizations to compete for contracts. This bidding process has proven to be highly ineffective and over time CCACs have proven to be less able to provide the coordinated, quality care that seniors and others deserve. According to Ontario's Action Plan for Health, there were 140,000 occasions in 2009 when patients were re-admitted to hospital within 30 days of discharge.<sup>62</sup> The Action Plan concludes that support is required to help individuals navigate the complexities of the health-care system.

There is no question that RN case managers and care co-ordinators currently working in CCACs will continue to play a valuable role in providing care co-ordination and system navigation to the ten per cent of Ontario's population that utilizes about 80 per cent of our health resources.<sup>63</sup> However, this co-ordination must occur within the primary care setting without layering the administration burden and duplication of CCACs, freeing up scarce funding for direct hours of home care and support services. RNAO's ECCO model holds health system navigation as a key component to successful health outcomes and provides that effective system navigation must occur within primary care.

LHINs are best positioned to provide the necessary planning, accountability, quality control and contract management within the home-care setting. Within the ECCO model, the LHIN will assume the contract management function of the CCAC and provide funds directly to the home care/support agencies. However, it is the primary care RN co-ordinator who initiates the care process by directly connecting with the home care/support organization. The home care/support

organization then has the ability to determine the level and type of care needed based on the patient's status within the funding basket provided.

Concern is mounting regarding the over emergence of for-profit providers, related to the competitive bidding process, given that research identifies that not-for-profit health services produce more quality patient outcomes and higher staffing hours of nursing care.<sup>64 65</sup> RNAO's ECCO model calls for an immediate moratorium on the development of new for-profit home care/support entities and calls for all home care/support organizations to be subject to accreditation. Contract renewal will be subject to a successful accreditation outcome. Moreover, the ECCO model requires home care providers to provide a broad range of services to prevent fragmentation and interrupted continuity.

A central feature of the ECCO model is the significant cost savings that it will produce for Ontario's health system through: reduced administration; elimination of unnecessary hospitalization; and a more efficient/effective method of delivering care to Ontarians. The ECCO model proposes that these savings be reinvested into front-line home care/support delivery to strengthen the sector and improve seniors' access to care within the home and community.

**Recommendation 16: Every older person in Ontario must live in dignity as independently as possible, and as a respected member of the community. This includes having access to expanded health-care services within the home as needed from a patient-centred inter-professional team.**

**Recommendation 17: Expand house calls in a cost-effective way by fully utilizing RNs and NPs rather than physicians.**

**Recommendation 18: Improve workforce stability by eliminating competitive bidding, and favour the not-for-profit sector in delivering home and community care.**

**Recommendation 19: Re-invest the substantial savings generated by the ECCO model, through reductions in unnecessary administration and reduced hospitalizations, into the community to expand the hours of direct home care service delivery.**

### **Long-Term Care**

Appropriately resourcing LTC homes to work in partnership with local hospital, primary care and home care organizations through the ECCO model, will enable hospitals to strategically reduce the need for alternate level of care (ALC) beds by accommodating more complex residents in LTC homes and supporting the transfer of less acute residents back into their homes. Close links with interprofessional primary care teams and an RN Care Coordinator ensure that every resident has access to the most appropriate services needed to facilitate patient-centred care.

Long-term care homes should embrace RNAO's Position Paper on Strengthening Client-Centred Care in Long-Term Care,<sup>66</sup> where each resident is assigned one RN or RPN per shift, with the most appropriate caregiver based on the resident's complexity and care needs and the degree to which outcomes are predictable. Evidence-based legislated minimum standards of care should be adopted, including funding for no less than an average of 4.0 hours of nursing care per resident, per day and no less than .59 RN hours per resident, per day; with greater acuity requiring more hours of care.<sup>67</sup> Resident clinical and social outcomes are maximized with a staff mix of: (1) one

NP per LTC Home, with no less than one NP per 120 residents, (2) at least 20 per cent RNs, (3) 25 per cent RPNs and (4) 55 per cent personal support workers (PSWs), subject to increases that align with greater acuity. Two RNs working 24/7 per 100 beds are the recommended minimum to allow for surge capacity as it becomes necessary.

Within RNAO's ECCO model, emphasis is placed on keeping seniors well within their homes and communities. When absolutely necessary, LTC home placement is co-ordinated seamlessly within primary care, embracing the patient's specific needs. The role of the LHIN will be to provide broad oversight of LTC functioning and to identify vacancies and waitlists. Together, these processes will provide a new experience for patient's seeking LTC home placement in an efficient and coordinated manner.

Evidence-based practice is a central concept that must apply to all sectors where care is delivered to seniors. RNAO's LTC Best Practices Initiative is a key support that assists LTC homes to implement RNAO's evidence based resources. Fourteen LTC Best Practice Coordinators support LTC homes within each LHIN to enhance the quality of evidence- based care being delivered through capacity building and supporting LTC staff and leaders to implement RNAO's Best Practice Guidelines. More specifically, the LTC Best Practices Initiative uses six approaches that would benefit the development of a seniors' strategy, including: raising awareness of evidence-based practice; engagement of LTC homes and sector-specific provincial partners; capacity building; implementation of best practice guidelines; integration of key drivers of system change impacting the LTC sector; and evaluating the impact of best practices on resident care.<sup>68</sup>

An impact evaluation conducted by the Nursing Health Services Research Unit (2006-2007) revealed that this initiative had been effective in increasing the awareness and uptake of best practice guidelines in the LTC sector and had benefits for both the residents and staff. To date, the LTC Best Practice Co-ordinators have been actively engaged with all 631 LTC homes throughout the province. These activities included individualized consultation and educational services to 508 or 80% of the LTC homes resulting in increased uptake of best practice guidelines and better resident outcomes. Additionally, LTC Best Practice Co-ordinators have worked to prepare some of the long-term care settings for adoption of evidence-based practice changes and enable others to take on long-term care organizational mentorship roles. More recently, a 2012 review of the LTC Best Practice Coordinator impact demonstrated over two-thirds of the LTC homes assessed were engaged in implementation of best practice guidelines, ranging from full implementation and sustained use, to early adoption. This shows considerable progress over the past seven years and confirms the significant impact of the LTC Best Practice Coordinator role in changing the culture of long-term care settings to reflect evidence-based practice.

These changes have been enabled through development of learning resources, and specific capacity building activities and services provided by the LTC Best Practice Co-ordinators. The LTC Best Practices Toolkit, developed through the initiative is an on-line collection that brings together evidence-based resources related to implementing and sustaining best practice guidelines relevant to LTC residents and staff. Over the three years since its development, this resource has been used by thousands from around the world and is lauded as the "go to resource" for LTC.

RNAO Best Practice Champions workshops in LTC have been used to build expertise of front-line staff by promoting and supporting knowledge transfer to facilitate BPG implementation within LTC homes. To date, there are 939 LTC Best Practice Champions throughout Ontario. In addition, nurses have been assisted to further skill development in BPG implementation through learning opportunities and clinical practice fellowships. A total of 493 nurses have attended RNAO conferences and learning institutes over the past seven years (BPG Institute 107; Healthy Work Environment Institute 47; International Elder Care Conference 119; Wound Care Institute 112; Chronic Disease Management Institute 13; and League of Excellence for Long-Term Care 95). The League of Excellence for Long-Term Care was developed for long-term care leaders to enhance their ability to facilitate quality and excellence in resident care and the work environment. Fifteen nurses from LTC have received fellowships through the Advanced Clinical Practice Fellowships Program. These fellowships have enabled nurses to take leadership roles in implementing best practice guidelines including falls prevention, management of delirium, depression and dementia, end-of-life care, pain, chronic disease management, constipation, and wound and skin care.

**Recommendation 20: Extend and expand the LTC Best Practices Initiative to increase the numbers of Best Practice Coordinators in each LHIN such that no coordinator has more than 50 long term care homes within their portfolio.**

**Recommendation 21: Introduce legislation to implement evidence-based minimum standards of nursing care in LTC homes to optimize outcomes such that staffing includes at a minimum, one nurse practitioner per LTC home with no less than one NP per 120 residents, at least 20 per cent RNs, 25 per cent RPNs and 55 per cent personal support workers, subject to increases due to greater acuity.**

**Recommendation 22: Introduce legislation to enable NPs to write admission, treatment, transfer and discharge orders in all Ontario LTC homes.**

### **Retirement Homes**

On June 8th, 2010, the *Retirement Homes Act* received Royal Assent. While the *Retirement Homes Act* was a welcome piece of legislation given the previous lack of regulatory oversight, RNAO and other seniors' advocacy groups expressed serious concerns that it would open the door to two-tiered health care for our seniors.

It is fundamental that regulation of retirement homes must not enable privately-owned, for-profit retirement homes to offer the same level of health services as LTC homes for those who can afford to pay privately. RNAO continues to urge the government in the strongest terms to correct the *Retirement Homes Act* immediately to impose a limit or cap on the health services that can be provided to retirement home residents. Residents with moderate to complex health needs and those with significant mental health needs must receive care in settings where they can receive appropriate health care rather than from a retirement home.<sup>69</sup>

**Recommendation 23: Changes be made to the *Retirement Homes Act* to impose a limit or cap on the health services that can be provided to residents of retirement homes. Residents**

**with moderate to complex health-care needs and those with significant mental health needs should not receive care from a retirement home.**

### **Ending Elder Abuse and Neglect**

Elder abuse has always been a priority issue for RNAO, recognizing the importance of keeping vulnerable seniors safe and secure. Abuse on the elderly can take many different forms, from physical, sexual or emotional to outright neglect or financial mistreatment. Regardless of the definition, RNAO is uncompromising in its commitment to seniors receiving the highest quality care and keeping elder abuse and neglect prominent on the agenda of our political leaders.

RNAO, in conjunction with the CNA and with funding from the federal government, launched the Prevention of Elder Abuse Centres of Excellence (PEACE) initiative in 2010 in 10 long-term care homes across the country. The project's aim was to provide nurses and other health providers with additional knowledge to identify and report elder abuse. Key deliverables of this successful project included: a curriculum focused on elder abuse awareness, prevention, detection and intervention, as well as key awareness raising resources. The implementation of the curriculum across the Canadian PEACE sites resulted in greater understanding and awareness of elder abuse among LTC staff and increased knowledge and confidence in prevention and intervention. Two formal PEACE sites have been established in Ontario, and the LTC Best Practice Coordinators are exploring how they can best use the resources and strategies in their consultation work with all LTC settings across the Province.

As a result of the PEACE Project, RNAO, through federal funding, is now developing a best practice guideline that will focus on how to identify abuse and strategies for intervention when instances of abuse are known or suspected. To assist organizations to implement the guideline, RNAO will also develop an e-learning tool, a health education fact sheet as well as indicators to chart the guideline's success.

In November, 2011, the Toronto Star exposed dozens of incidents of aggression and abuse that had occurred in several long-term care homes, which were not reported to authorities or were delayed. This led to the establishment of the Long-Term Care Task Force on Resident Care and Safety with Dr. Gail Donner as Chair. RNAO was an active participant of this Task Force. The distressing extent of the problem could not be exaggerated. As the Task Force found, there were more than 3,200 incidents of abuse and neglect reported to MOHLTC in 2011 alone, about 3.5 cases per 100 nursing home beds. Resident-on-resident abuse accounted for about half of the cases, while staff abusing residents under their care comprised about one-third. In May, 2012, the Task Force released its action plan to address elder abuse and neglect, consisting of 18 actions that include a "zero tolerance" policy on abuse and neglect, whistleblower protection and more education for staff.<sup>70</sup>

**Recommendation 24: Protect our seniors from abuse and neglect by fully implementing the 18 actions recommended by the Long-Term Care Task Force on Resident Care and Safety.**

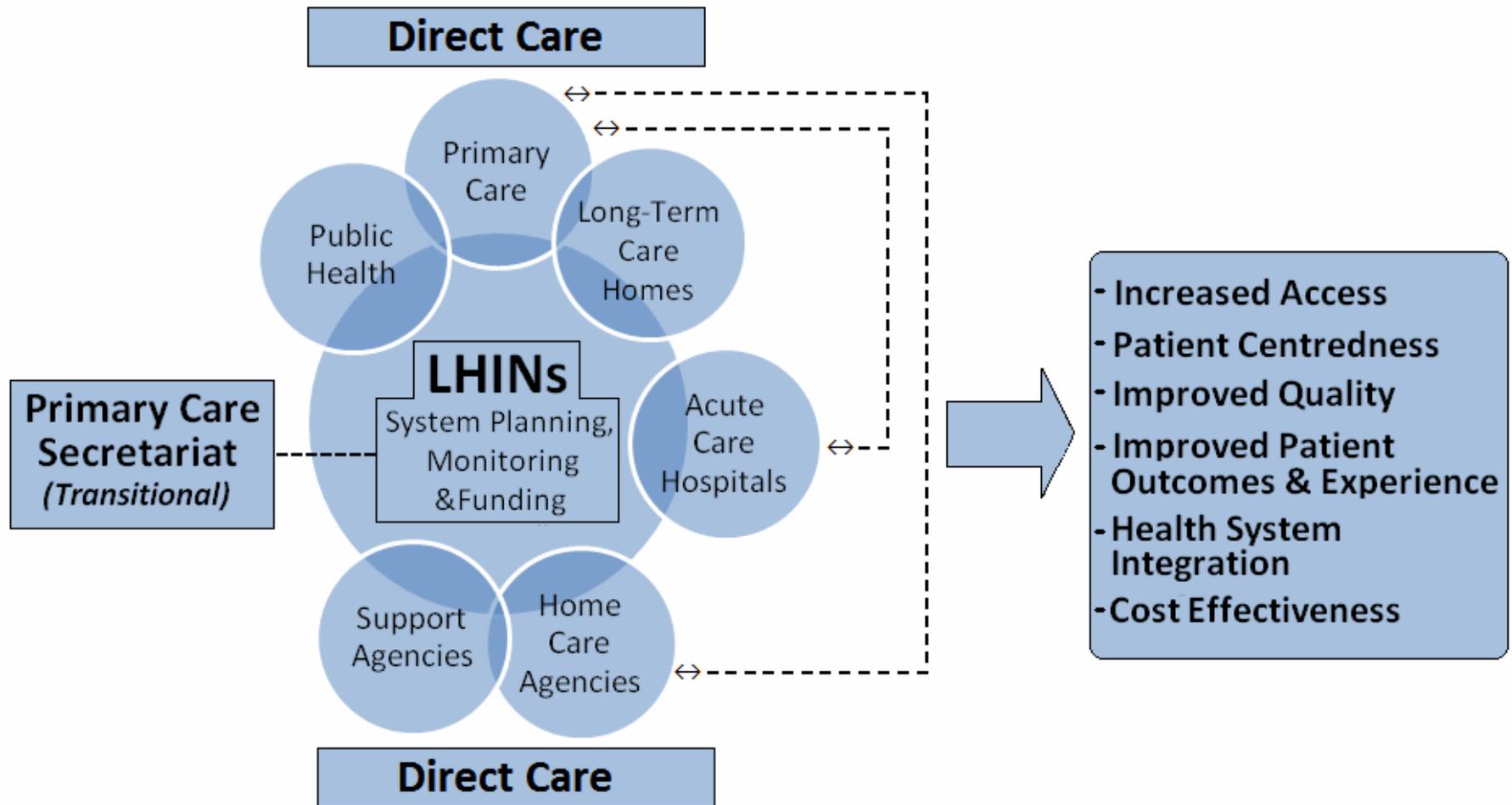
**Recommendation 25: Support the LTC Coordinators as part of the Long Term Care BPG Initiative to implement the PEACE elder abuse curriculum and other strategies along with the Prevention and Management of Elder Abuse BPG in all long term care homes throughout Ontario.**

**Conclusion**

RNAO commends the provincial government and MOHLTC for undertaking the crucial mission to develop a Seniors' Care Strategy for Ontario. RNAO is committed to working with the Ministry and stakeholders to develop and fully implement without delay, a Seniors' Care Strategy that is principled, comprehensive, integrated and aligned with best evidence. The results will be healthier seniors and communities, and a stronger health system for all.

Appendix A:

Enhancing Community Care for Ontarians (ECCO) Model



**Appendix B: Recommendations of the Primary Care Nurse Task Force**  
*(Primary Solutions for Primary Care Report)*

**Phase One**

Recommendation	Accountability	Proposed Timeline
<b>Implementation and Evaluation</b>		
1) Appoint a six month government committee, co-sponsored by RNAO and the Ministry of Health and Long-Term Care, with representation from professional associations, regulatory bodies and primary care associations, to roll-out the timely and effective implementation and evaluation of the recommendations in this report.	Ministry of Health and Long-Term Care  Registered Nurses' Association of Ontario	Immediately
<b>Role Direction Phase I</b>		
2) Issue directives, with specific timelines, for the upward harmonization of RN and RPN scope of practice across all primary care settings, as a first step to maximize all roles within the interprofessional team.	Ministry of Health and Long-Term Care  Local Health Integration Networks	Immediate directive provided, with role maximization compliance required by December 31, 2013
3) Issue a directive to primary care organizations to formally designate a nurse lead to spend a portion of her/his role advising the management team and board of directors from a nursing perspective.	Ministry of Health and Long-Term Care  Local Health Integration Networks	Immediate directive provided, with designated nurse lead compliance required by December 31, 2013
<b>Education and Support Phase I</b>		
4) RNs and RPNs, currently working in primary care, self-assess their educational needs and engage in educational programs to meet the requirement of phase one role description.	Primary Care Organizations  Primary care RNs/RPNs	Immediate directive to self-assess, with role maximization compliance required by December 31, 2013
5) Support primary care nurses to practise	Primary Care	Immediate, with role

Recommendation	Accountability	Proposed Timeline
to full scope within interprofessional teams, using the phase one role description developed by the Task Force as a resource. This includes providing the necessary mentorship, team building, team roles clarification, and acknowledgment of local support needs.	Organizations	maximization compliance required by December 31, 2013
6) Fund RNAO to develop a primary care nursing-focused learning institute for RNs and RPNs to strengthen the knowledge, skill and confidence of primary care nurses.	Ministry of Health and Long-Term Care	Immediate funding provided with first learning institute offered by December 31, 2012
7) Secure clinical placements in primary care practice for RN and RPN students.	Schools of Nursing  Primary Care Organizations	Immediate initiation with full compliance by December 31, 2013
<b>Primary Care Funding</b>		
8) Work to further reform physician compensation models in a way that advances full utilization of nurses and all other health professionals, while ensuring fair compensation for physicians.	Ministry of Health and Long-Term Care  Ontario Medical Association	Immediate as part of current (2012) negotiations with the Ontario Medical Association
9) Develop a uniform and streamlined process to apply for additional funding to increase health human resources for primary care organizations, such as CHCs, FHTs, and NPLCs, when patient enrollment targets are met, and infrastructure capacity exists.	Ministry of Health and Long-Term Care	Immediate with uniform and streamlined application process in place by December 31, 2012

## Phase Two

Recommendation	Accountability	Proposed Timeline
<b>Legislation</b>		

Recommendation	Accountability	Proposed Timeline
10) Amend the Nursing Act, 1991 and associated regulations to authorize RNs in the general class to: <ul style="list-style-type: none"> <li>• prescribe medication to prevent and/or treat health conditions, chronic disease and episodic illness within their level of competency;</li> <li>• compound and sell medication;</li> <li>• identify and communicate a diagnosis within their level of competency; and</li> <li>• order diagnostic imaging.</li> </ul>	Government of Ontario  College of Nurses of Ontario	Achieved by January 1, 2014
11) Amend the Laboratory and Specimen Collection Centre Licensing Act and associated regulations to authorize RNs in the general class to order laboratory tests.	Government of Ontario  College of Nurses of Ontario	Achieved by January 1, 2014
12) Implement regulations under the Regulated Health Professions Statute Law Amendment Act, 2009 to authorize RNs in the general class and RPNs to dispense medication.	College of Nurses of Ontario	Achieved by January 1, 2013
<b>Role Direction Phase II</b>		
13) Issue directives with specific timelines for the expanded scope of practice utilization of RNs, to include RN prescribing and care co-ordination, for all primary care organizations.	Ministry of Health and Long-Term Care  Local Health Integration Networks	Directive issued in January, 2014, with expanded scope of practice role compliance by December 31, 2015
14) Support RPNs in executing clinical and educational programs to advance health promotion and disease prevention.	Primary care organizations	Expanded scope of practice role compliance by December 31, 2015
<b>Education and Support Phase II</b>		
15) Fund and develop focused pharmacology/diagnostic courses (i.e. 300 hour nurse prescribing course offered in the UK) that expand on the experiences	Ministry of Training, Colleges and Universities (funder)	Funds made available in February 2014. Course developed and offered by September 2014

Recommendation	Accountability	Proposed Timeline
and competencies of current RNs to prepare them for an expanded role, while enhancing current nursing education programs and supporting nursing faculty to incorporate an expanded RN role into nursing curricula.	Educational institutions	
16) Establish a certification program to promote professional development and knowledge advancement and acknowledge the unique competencies of primary care nurses.	Canadian Nurses Association	By January 1, 2015
<b>Health System Enhancement</b>		
17) Identify areas of structural duplication and work toward better system integration by improving linkages across all sectors and moving care co-ordination to primary care.	Ministry of Health and Long-Term Care	Process and transition completed by January 1, 2015
18) Establish tripartite leadership councils within Local Health Integration Networks, including one representative from: nursing, medicine, and another health profession that is not medicine or nursing (i.e. pharmacist, physiotherapist, occupational therapist, etc.) to provide clinical and human resources advice to LHINs.	Ministry of Health and Long-Term Care  Local Health Integration Networks	Model and selection process developed by January 1, 2013. Councils in place in each LHIN by January 1, 2014
<b>Nursing Human Resources</b>		
19) Provide primary care organizations with the funding required to offer competitive compensation and benefits to primary care nurses and other health professionals, eliminating inequities with other sectors of the health system.	Ministry of Health and Long-Term Care  Local Health Integration Networks	By January 1, 2015
20) Support and fund strategies that will ensure at least 70 per cent of primary care	Ministry of Health and	Directive issued by January 2014, with 70 per

Recommendation	Accountability	Proposed Timeline
nurses are working full-time.	<p>Long-Term Care</p> <p>Local Health Integration Networks</p> <p>Primary care organizations</p>	<p>cent full-time employment target in all primary care settings achieved by December 31, 2015</p>

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