RNAO Pre-budget Submission 2020:

Investing in Health

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The Registered Nurses' Association of Ontario (RNAO) represents registered nurses (RN), nurse practitioners (NP), and nursing students , and for nearly a century has advocated for changes that improve people's health. RNAO welcomes this chance to talk about our province's spending priorities to the Standing Committee on Finance and Economic Affairs.

Our submission focuses on four urgent health issues: health system reform, primary care, long-term care and the opioid overdose crisis.

Health System Reform in Ontario

Recommendation:

1. *Commit to adding 2,500 RN Full-Time Equivalents per year, to begin catching up with the rest of the country's RN to patient ratios.*

Ontario has embarked on an ambitious plan to reorganize its health system around Ontario Health Teams (OHT), with the stated intention of better integrating health care, delivering a more seamless health system experience for patients, and empowering people to engage in their own care.[1]

RNAO applauds health system transformation that increases access, equity and integration. Key health system performance indicators point to the need for improvement. For example: Timely access to primary care providers has been dropping in Ontario. In 2013, 45.3 per cent of Ontarians were able to see their primary care provider by the next day when they were sick. That already poor number dropped to 40.4 per cent by 2018. The provincial averages disguise some profound inequities in access. In the North East LHIN, only 29.1 per cent had access to a primary care provider within a day and in the North West LHIN that number is only 22.9 per cent. [2]

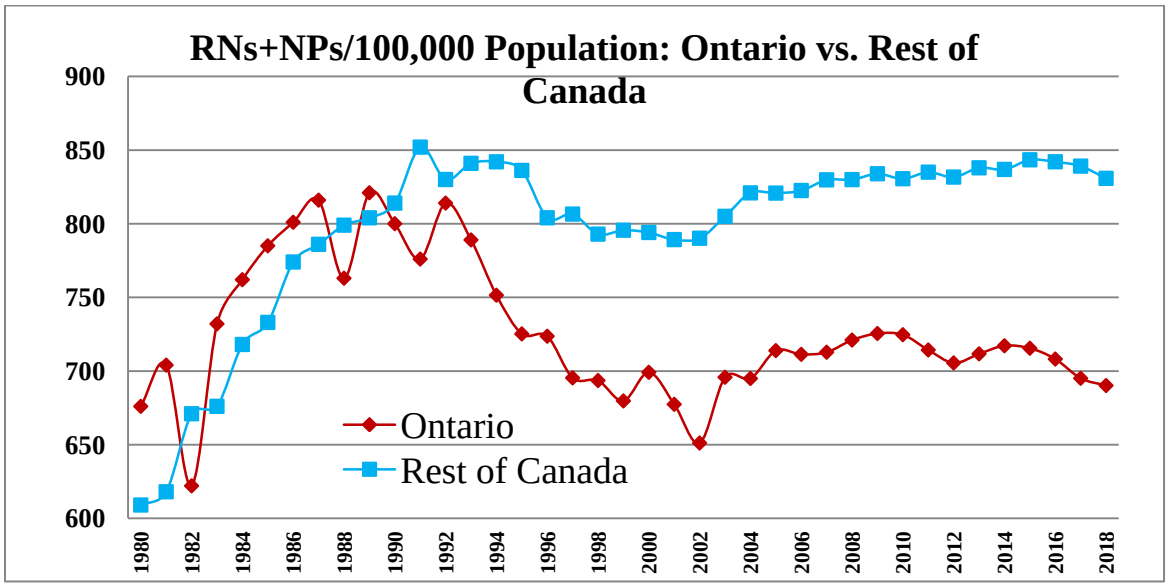
System integration is severely hampered by the lack of interprofessional team-based care and the lack of nurse care coordination in primary care. The majority of primary care physicians (54.7 per cent in 2017) are not connected to interprofessional teams and care coordination is largely performed by hospitals and the soon-to-be defunct LHINs. The growth in emergency room visits, record wait times for hospital admission via emergency rooms,[3] time spent in hospital awaiting alternative levels of care (home care, rehab and long-term care),[4] the normality of hospitals operating beyond capacity (for the first half of 2019, out of 169 sites, 83 hospitals were beyond capacity for over 30 days, 39 were above 120 per cent capacity for at least a day, and 40 averaged over 100 per cent capacity),[5] and the extent of hallway healthcare (with 1,000 people receiving

care daily in hospital hallways),[6] all point to current access, equity and integration problems in our health system.

RNAO has committed itself to ensuring the success of the current transformation. We have adapted our Best Practice Spotlight Organization (BPSO) program to also embrace and support Ontario Health Teams (OHTs)[7] and are, currently, supporting four OHTs with adoption and implementation of Best Practice Guidelines (BPG) across all partners and all sectors. (Three additional BPSO OHTs will soon be accepted).

The success of health system transformation also depends on ensuring sufficient employment and strategic deployment of RNs and NPs. Having these nurses working at full scope is central to improving access to, equity in and integration of the health system.

However, a gap of over 20,000 RNs and NPs separates Ontario from the other provinces and territories, as the graph below shows.



Ontarians are missing out on all the services that nurses would have supplied including, but not limited to:

- monitoring patient health
- coordinating care and guiding patients and families through the system
- connecting patients to necessary social supports and services
- reaching out into non-traditional settings, such as shelters and streets, to ensure that marginalized populations are brought into our system of care
- providing care in the home, and
- safe and quality care in all long-term care homes

It is important not only to restore RN and NP employment, but also to make full use of RN and NPs knowledge, competencies and skills by ensuring that they work to full scope and expanded scope. For example, the government must deliver on the promise to expand NP authority to order and perform diagnostic testing necessary to their patients care, and to enable independent RN prescribing of medication for non-complex health conditions within their clinical competency area.[8]

The Ontario RN shortfall is long-standing and has gotten worse over time. It won't be fixed overnight, but it is essential to move now and ensure the success of the government's health system transformation. The year 2020 marks the year of the nurse, and thus it is worth noting that the World Health Organization identifies nurses as key to providing and ensuring universal access to health care.[9]

Primary Care

Recommendations:

2. *Transfer funding as appropriate to ensure that the 4,500 RNs currently working as care coordinators in LHINs are transitioned to primary care and other community-based organizations, with their contracts intact and no loss in compensation, benefits or seniority.*

3. *Invest funding to allow NP-led clinics to open in communities where there is or will be insufficient access to primary care services.*

> "Primary care is the provision of *integrated, accessible health care services* by clinicians who are *accountable* for addressing a large *majority of personal health care needs*, developing a *sustained partnership* with *patients*, and practicing in the *context of family and community."*[10]

The old image of primary care is of a family doctor working in independent practice, perhaps supported by an RN. That is changing as more NPs become primary care providers. Primary care has also been delivered for many years by teams of health professionals including RNs and NPs in settings such as community health centres. Increasingly, primary care is being delivered by teams of physicians and other health professionals. That trend will accelerate with the formation of Ontario Health Teams. The expansion of interdisciplinary care is long-overdue and will improve access to and integration of health-care services.

Reuben Devlin's report on hallway health care identifies the crucial role that primary care ought to play in providing patient navigation, coordination and the appropriate mix of services.[11] The second Devlin report, in particular, recommends that supports for patients and providers be provided "at every step of a health care journey by ensuring effective primary care is the foundation of an integrated health care system."[12] The

government health system vision is informed by this understanding, and RNAO is hopeful that the centrality of primary care and primary care teams in OHTs will be realized in the process.

RNAO's vision for primary care reform is as follows:

- Ensure all Ontarians are linked to a primary care team
- Make primary care available 24/7 for all Ontarians
- Locate care coordination in primary care
- Expand the care coordinator role to provide comprehensive and consistent service for all Ontarians
- Ensure care coordination includes linkage to social services
- Deliver approaches to health care that are person-centred, incorporate prevention and health promotion and integrate equity and community engagement
- Ensure that all primary care is provided through an inter-professional team-based model
- Enable primary care to play a leadership role in Ontario Health and Ontario Health Teams

RNs are positioned to enhance access to primary care not just through care coordination. Already, 25 NP-led clinics are delivering a full suite of primary care services, and there is the need for many more, such as the proposed site in Midland.

Long-Term Care

Recommendations:

4. *Release the funding committed for the remaining 15 Attending NP positions in long-term care of the 75 positions that were to be released in the current budget year.*[13]

5. *Commit funding to add 50 Attending NPs in long-term care positions per year in order to move towards appropriate staffing levels.*

6. *Review and transform funding models in LTC to account for both complexity of resident care needs and quality outcomes. LTC homes that decrease acuity (CMI) due to evidence-based care should retain all funding to reinvest in staffing and/or programs for residents.*

7. *Increase direct care per resident day in LTC to four hours, as per Ontario's Action Plan for Seniors.*

8. *Mandate by 2025 a nursing and personal care staffing skill mix of at least 20 per cent RNs, inclusive of NPs and Clinical Nurse Specialists, and 25 per cent RPNs (and no more than 55 per cent personal support workers (PSW)).*

Gaps are all-too evident to those in the long-term care system, with very long admission wait times (163 days from the community and 94 days from hospitals) ,[14] excessive use of anti-psychotics on patients not living with psychosis (19.6 percent in 2017-18),[15] and rising fall rates (which went from 13.9 residents per month falling in 2010/11 to 16.4 in 2017/18).[16]

The Public Inquiry into the Safety and Security of Residents in Long-Term Care called for the government to study the adequacy of staffing levels for registered staff in long-term care and report back this July.[17] We know enough to start investing in safer long-term care (LTC) staffing now. Direct care per resident day in LTC must rise to four hours, as per Ontario's Action Plan for Seniors.[18] For years, RNAO has also been calling on the government to legislate minimum nursing and personal care staffing and skill mix standards in LTC, accompanied by the necessary funding to support these changes. We urge no less than one Attending NP for every 120 residents, and a nursing and personal care skill mix consisting of at least 20 per cent RNs, inclusive of NPs and Clinical Nurse Specialists, 25 per cent RPNs, and no more than 55 per cent PSWs.

The government has promised funding for 75 Attending NPs in LTC, and that is a good start. Money has been released for 60 NPs, but funding for the remaining 15 positions should be released. To get to one NP per 120 residents, we need another 575 Attending NPs in LTC. We must add at least 50 Attending NP positions per year to start moving Ontario towards appropriate staffing levels.

The government is also investing in more beds for long-term care,[19] and the long admission wait times tell us the beds are overdue. More staffing will be required for those extra beds as well. The need will only increase as Ontario's population continues to age. Direct care staffing must rise to meet both existing and expected need.

In the process of reforming payments to health provider organizations, it is essential to use funding methodologies that provide the correct incentives. In LTC, homes that improve health outcomes end up losing money because their case mix index (CMI) falls. This is a disincentive to improve outcomes, and LTC homes must be allowed to keep their funding and not be penalized for good quality care.[20]

Consumption and Treatment Services (CTS)

Recommendations:

9. *a. Commit to approval and funding for CTS sites in communities where there is a need and where organizations are able and willing to create the sites.*

   b. In the interim, commit funding for the five of the 21 CTS sites that have been allowed for (above the 16 currently operating), and streamline and expedite the CTS application process to ensure that all 21 sites are open as soon as possible.

   c. Increase funding for all existing CTS sites to deliver the staffing levels essential to meeting demand for services.

The opioid epidemic has struck Ontario hard, as it has struck the other provinces, and the situation continues to get worse. There are many causes, including misleading marketing, over-prescribing and a myriad of social factors. The number of overdose fatalities in Ontario has risen from 676 in 2014 to 1,473 in 2018,[21] with Ontario's January to June 2019 rate per 100,000 of 13.0 exceeding the national average of 11.5, and only exceeded by BC and Alberta.[22] The ultimate solution is to address the social and industry causes of the problem, but we also face a humanitarian crisis of keeping people alive. Consumption and Treatment Services (CTS) provide the supervised consumption that saves lives, yet the government has capped the number of CTS sites at 21,[23] of which 16 are currently up and operating. Existing facilities are under-staffed and many communities are underserviced or unserviced. Lives are being lost and that is never acceptable.

Appendix: Costing

1. **Commit to adding 2,500 RN Full Time Equivalents per year, to start to catch up with the rest of the country.**

   Estimated first year cost: $252M, based on a 24% employment cost and average wage rate at the 5 year level in the ONA OHA RN contract ($95,269 per RN), with 250 NPs among the 2,500 RNs. NPs at $114,340 + 24% employment costs +$8,513 overhead.

2. **Transfer funding as appropriate to ensure that the 4,500 RNs currently working as care coordinators in LHINs are transitioned to primary care and other community-based organizations, with their contracts intact and no loss to compensation, benefits or seniority.**

   Minimal budgetary implication, as this will just transfer payments to different employers.

3. **Invest funding to allow NP-led clinics to open in communities where there is or will be insufficient access to primary care services.**

   Expected cost: An average clinic gets a budgeted $1.635 million: $42.5M/26 NPLCs, but costs will vary according to the staffing and other costs of the NPLC. This cost will be completely offset by the savings achieved in hospital Emergency Department visits and preventable hospitalizations resulting from delayed care due to inadequate access to primary care.

4. **Release the funding committed for the remaining 15 Attending NP positions in long-term care of the 75 positions that were to be released in the current budget year.**

   Estimated cost: $2,254,419, based on $114,340 per NP + 24% employment costs +overhead; this should already have been budgeted for.

5. **Commit funding to add 50 Attending NPs in long-term care positions per year in order to move towards appropriate staffing levels.**

   Estimated cost: $7.515 M based on $114,340 per NP + 24% employment costs +overhead; this is included in the 2,500 RN costing from Recommendation 1.

6. **Review and transform funding models in LTC to account for both complexity of resident care needs and quality outcomes. LTC homes that decrease acuity (CMI) due to evidence-based care should retain all funding to reinvest in staffing and/or programs for residents.**

   Positive budgetary implication, as more appropriate incentives will drive the efficiency that would save more money than clawbacks would produce, while incentivizing safe and quality care and resident satisfaction.

7. **Increase direct care per resident day in LTC to four hours, as per Ontario's Action Plan for Seniors.**

Estimated cost for RNs and NPs included in Recommendation 1.

8. **Mandate by 2025 a nursing and personal care staffing skill mix in LTC of at least 20 per cent RNs, inclusive of NPs and Clinical Nurse Specialists, and 25 per cent RPNs (and no more than 55 per cent personal support workers (PSW)).**

   Estimated cost RNs and NPs included in Recommendation 1.

9. **a. Commit to approval and funding for CTS sites in communities where there is a need and where organizations are able and willing to create the sites.**

   Estimated operating cost: Depends upon number of sites and scales of operations. Kitchener is getting $1.6 million for operating costs,[24] as an example of current funding levels.

   b. In the interim, commit funding for the five of the 21 CTS sites that have been allowed for (above the 16 currently operating), and streamline and expedite the CTS application process to ensure that all 21 sites are open as soon as possible.

   Estimated operating cost: $8 million, based on Kitchener's operating budget.

   c. Increase funding for all existing CTS sites to deliver the staffing levels essential to meeting demand for services.

   Estimated cost: $5 million per year to increase staff resourcing and project supports, per Alliance for Healthier Communities 2020 pre-budget submission.

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