# RNAO Fall Pre-budget Submission 2020:

The Pandemic Recovery

Oct. 16, 2020

## RNAO Fall 2020 Pre-Budget Submission

The Registered Nurses' Association of Ontario (RNAO) represents registered nurses (RN), nurse practitioners (NP) and nursing students across the province, and for nearly a century has advocated for changes that improve people's health. RNAO welcomes the opportunity to present to the minister of finance the views of nurses concerning Ontario's spending priorities.

Our submission focuses on urgent challenges facing vulnerable populations, including the frail elderly and other marginalized groups. We consider first the escalating crisis in long-term care (LTC) and the pressing need for staffing and resources in that sector in order to avoid a repeat of the horrific tragedy that befell LTC residents in the spring of 2020. Recognizing the inextricable connections between sectors within the health system, we urge a more expeditious transformation of the health system, with Ontario Health Teams anchored in primary care and the community care sector. To begin, investments must focus urgently on key priority areas: 1) LTC, 2) primary care, and 3) home care. The goal here is to:

- build a comprehensive primary care system that ensures everyone has co-ordinated care and gets appropriate attention in the health system so that interventions happen before ailments become acute or chronic;
- deliver home care that enables people to age in place, rather than become institutionalized in nursing homes; and
- proactively work on sustaining older persons and other vulnerable populations as vibrant members of our communities, and do all we can to prevent institutionalization (i.e., nursing homes, shelters, corrections, and others).

Our proposed action in the sectors noted above will benefit all Ontarians, and it will particularly benefit frail elderly and other vulnerable populations. This is not only a sectored investment; it is a targeted and purposeful investment in vulnerable communities so no one is left behind. First, we must do much better at addressing Indigenous people's health. First Nations in Canada were colonized in a way that was devastating for their culture and their health, and we have yet to close the shocking gap between life chances in their communities compared to the rest of Ontario. This requires a concerted effort to work with First Nations to build a health system that meets their pressing and long-term needs. They must lead and we must support.

We must also work even further upstream to address all determinants of health. It is far better to fix the circumstances in which people live than to abandon them to lives of misery and illness. In particular, access to safe and healthy housing is one of the most powerful determinants of health. Without it, people face continuous stress and they fall prey to acute

and chronic diseases. In the end, these increased needs cost the health system dearly. Investing in housing is one of the wisest health investments society can make.

In addition, with the objective of health equity, investments must be redirected from policing and incarceration to education and community infrastructure, particularly in racialized and marginalized communities, to ensure all children and youth have full opportunity for safe, healthy and productive lives. Further, those experiencing mental health and addiction issues require government supports and services. Almost lost in the justified concern about the COVID-19 pandemic is the fact that a toxic drug supply is killing an average of five people per day in Ontario.[1] Life has become even more hazardous for substance users during the pandemic, yet we know we can save many lives by delivering necessary harm reduction services.

## 1. Health Transformation and Ontario Health Teams

**Recommendation:**

*A. Transfer funding as appropriate to ensure the 4,500 RNs currently working as care co-ordinators in LHINs are transitioned to primary care and other community-based organizations, with their contracts intact and no loss in compensation, benefits or seniority. [See same under Primary Care, below].*

A dedicated care co-ordinator position is required as part of an interprofessional team.[2] The overarching purpose of the care co-ordinator role is to:

- be a consistent contact for each Ontarian throughout their interactions across the health system,
- facilitate access to interprofessional and specialized care for patients, and
- help patients and families navigate programs and services across the health system.

Primary care RNs must take a lead role in care co-ordination and system navigation in collaboration with other qualified professionals within the interprofessional team. RNAO's ECCO 3.0 model urges the transition of the approximately 4,500 care co-ordinators currently employed within LHINs (and not performing hospital discharge functions) into interprofessional primary care teams, with their salary and benefits intact.

Primary care-based, RN-led care co-ordination for complex populations is well supported within the scientific literature.[3] [4] [5] [6] [7] [8] RN care co-ordinators can contribute their expertise and system knowledge by providing dedicated and comprehensive care co-ordination and health system navigation to Ontarians with the most complex needs.

RNAO is supporting the success of Ontario Health Teams (OHT) by offering a new Best Practice Spotlight Organization (BPSO) model called BPSO OHT. Currently, there are four OHTs participating in this program: North Western Toronto, East Toronto Health Partners, Southlake Community and Ottawa East Health Team/ Équipe Santé Ottawa Est. Many others are ready and eager to join.

This BPSO OHT model is designed to support OHTs across the continuum of care to achieve the quadruple aim of: improved patient outcomes, improved patient experience, lower costs of care and improved provider experience. The goal of the BPSO OHT model is to optimize patient outcomes through evidence-based practice and robust staff engagement, including all disciplines and all sectors.

BPSO OHTs are actively supported by RNAO and organizations throughout the BPSO OHT network to systematically implement evidence-based best practice guidelines (BPG) that align with government and individual BPSO OHT priorities. Mandatory guidelines for implementation include *Person-and Family-Centred Care* and *Care Transitions*. BPSO OHTs select two additional clinical guidelines according to their priority populations such as falls and injury prevention; pressure injury prevention; substance use; and more.

## 2. Long-Term Care

**Recommendations:**

*B. Amend the Long-Term Care Homes Act to mandate that all LTC homes establish processes to reunite families as care partners in LTC and implement them immediately, using RNAO's Reuniting Families Guide.*

*C. Immediately mandate and fund all long-term care homes to deliver a minimum of four worked hours of direct nursing and personal care per resident-day, including a minimum of 48 minutes of RN care, 60 minutes of RPN care and 132 minutes of PSW care.*

*D. Fund an LTC staff recruitment plan modeled after the RNAO Nursing Home Basic Care Guarantee to enable: the above four worked hours of direct care per resident-day, including a mix of RNs, RPNs and PSWs, as well as NPs; equity of compensation and benefits with the hospital sector; and offers of full-time work.*

*E. Release the funding committed for the remaining 15 Attending NP positions of the 75 positions that were to be released in the current budget year.*[9] [10]

F. *Commit funding to add 50 Attending NPs in LTC positions per year in order to move towards appropriate staffing levels.*

G. *Fully support national standards for LTC homes in Canada, using RNAO's Nursing Home Basic Care Guarantee as the basis for these national standards. Ontario's support should tie federal transfer payments to the successful delivery of those standards within the jurisdiction. As we have learned from previous national initiatives, in particular in relation to health care, this is the best way to ensure that such standards are developed and implemented in a timely manner.*

H. *Mandate the use of best practices for all nursing homes by supporting the insertion of RNAO's Best Practice Guidelines in Electronic Medical Records and RNAO's ongoing coaching.*

*I. Fund and direct the two-year RPN diploma programs and four-year RN nursing degree programs to incorporate a mandatory four-week practicum in an LTC setting as a part of the curriculum.*

J. *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.*

The most pressing issue in LTC is staffing. Two decades of research outlined in 35 reports flag staffing shortages in Ontario's LTC sector, as was demonstrated in a summary RNAO released in June, 2020.[11] Chronic short-staffing affects all LTC services, including infection prevention and control (IPAC). Based on overwhelming evidence, the government's LTC Staffing Study Advisory Group recommended increased funding to raise LTC staffing to a minimum daily average of four worked hours of direct care per resident. It also advised expanded use of nurse practitioners (NP), ensuring access to strong infection protection and control (IPAC), improvement of workload, greater access to full-time employment and greater compensation equity among all sectors.[12]

Ontario has entered the second wave of the COVID-19 pandemic, and that has massive health and economic implications. There were 783 new COVID-19 cases on Oct. 14, bringing the total to 62,196 since Jan. 15. Of Ontario's 3,022 COVID-19 related deaths to date, 1,977 (65 per cent) were in LTC, including eight LTC workers.[13] RNAO estimates that Ontario LTC residents were 354 times more likely to die of COVID-19 related illness than other Ontarians,[14] and LTC health workers were about eight times more likely to contract the disease than other Ontarians.[15]

As of Oct. 12, Ontario had 71 nursing homes with COVID-19 outbreaks with 199 active cases among staff alone. A further 292 LTC homes had resolved outbreaks.[16] Immediate increases in

resources and staffing in LTC are absolutely essential to prevent a repeat of the avoidable tragedy that took place in the sector during the first wave of the pandemic.

RNAO's *Nursing Home Basic Care Guarantee* specifies that the staffing increase must be a minimum of four worked hours of direct personal and nursing care per resident per 24 hours. Of these four hours RNAO calls for 48 minutes of nursing care provided by registered nurses (RN) (20 per cent), 60 minutes provided by registered practical nurses (RPN) (25 per cent), and 132 minutes of personal care provided by personal support workers (PSW) (55 per cent). In addition, each nursing home should be funded for one nurse practitioner (NP) per 120 residents, in the role of Attending NP or Director of Clinical Care. If it is not possible to hire an NP, a Clinical Nurse Specialist (CNS) should be hired. Furthermore, each home should be funded for one additional nursing full-time equivalent (FTE) staff (preferably an RN) to support the functions of infection prevention and control, quality improvement, staff education, on-boarding and orientation.[17]

### 3. Primary Care

**Recommendations:**

*K. Fund interprofessional primary care to ensure all Ontarians are linked with a primary care team, delivering 24/7 comprehensive care coordination.*

*L. Fund primary care models based on the implementation of a primary health-care approach, inclusive of upstream social and environmental determinants of health.*

*M. 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.*

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

The Ontario Health Team framework, presently being implemented as part of the province's health transformation agenda, provides an ideal opportunity to better anchor the entire system in primary care, with strong and robust links to all sectors of the system. In our current situation, amidst a major pandemic, much of the primary care and community based components of the health system have been virtually shut down and deemed as dispensable. Such an imbalanced approach to guarding the health of the population has left a huge majority of Ontarians without services that are necessary in managing chronic conditions, preventing exacerbations, enabling early detection and promoting overall health.

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 co-ordination in primary care
- Expand the care co-ordinator role to provide comprehensive and consistent service for all Ontarians
- Ensure care co-ordination 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 co-ordination. 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.

**4. <u>Home Care</u>**

**Recommendations:**

*O. Increase the public funding to home care services by 20 per cent to enable increased access to home care.*

*P. Award contracts for home-care providers that can deliver a broad range of nursing and support care services 24/7 to avoid fragmented care.*

*Q. Award contracts with a preference for home-care agencies that are Best Practice Spotlight Organizations, as they have proven to deliver better health, clinical and satisfaction outcomes for Ontarians.*

*R. In keeping with the Ontario Health Teams framework, ensure any dollars saved from increased integration, care coordination and better outcomes are re-invested into additional access to home care services for Ontarians and not to profit-making.*

Home care was slated to consume just 5.5 per cent of ministry operating expenditures.[18] Yet people want to stay in their homes and we know that fully one in nine Canadian LTC placements would have been able to, had proper home supports been available.[19] This would greatly improve the quality of life and the health and functionality of thousands of Ontarians. It would also help to take some of the pressure off the very long wait lists in LTC. That, in turn, would help to reduce hallway medicine in hospitals that are housing thousands of alternate

level of care patients who are awaiting discharge to LTC or some other safe setting, such as their homes.

### 5. Public Health

**Recommendation:**

*S. At a minimum, maintain and extend the current level of surge funding for public health beyond the pandemic, including making permanent the 625 new public health nurse positions in Ontario schools.*

Public health is the health system's first line of defense against infectious diseases, and under the new government, it experienced serious cuts. Belatedly, some investments have flowed into public health by the way of 625 temporary public health nursing positions in public schools, to respond to the pandemic crisis. RNAO has deep concerns about the haste with which schools were opened while community spread of COVID-19 was not contained and without adequate provision for physical distancing.[20] Nevertheless, RNAO supports the addition of the 625 public health nurses to Ontario schools, but urges that those positions be made permanent.

More generally, a strengthened public health system is the best health investment Ontario could make at any time, and it is absolutely essential under the threat of pandemics.

### 6. Housing

**Recommendations:**

*T. Invoke the following measures to arrest the flow of people into homelessness:*
   *a. Re-impose the provincial moratorium on evictions of those unable to pay rent;*
   *b. Deploy as much as possible of the $1.4 billion funding for rent payment support under the Canada-Ontario Housing Benefit and double Ontario's contribution of $700 million.*

*U. Work with municipalities, Indigenous governing organizations and housing associations and not-for-profit housing associations to assist with programs and funding to rapidly house people experiencing homelessness, including:*
   *a. Immediately deploy Ontario's share (about $400 million) of federal funding under the $1 billion Rapid Housing Initiative to acquire, develop and maintain affordable housing and match that with Ontario's own contribution of $400 million.*
   *b. Provide additional funds to support the provision of wrap-around services for those housed through the Rapid Housing Initiative.*

Having a home in which one can safely distance from others remains the most effective means of protecting against COVID-19. Emergency measures to stop the flow of the precariously

housed into homelessness and rapidly house those experiencing homelessness must, therefore, be policy and spending priorities for the government for as long as the virus remains a public health threat.

Nearly 100,000 Ontarians experience homelessness every year. On any given day, nearly 10,000 people turn to municipal emergency shelter systems or sleep in the rough. COVID-19 has had a devastating impact on shelter options for people experiencing homelessness. Toronto's shelter capacity, for example, has been halved in order to provide necessary physical distancing. Municipalities across the province have provided temporary emergency shelter through lease arrangements of distressed properties, usually hotels and motels. Out of necessity and fear, hundreds of people experiencing homeless people have sought refuge in outdoor encampments.

Homelessness in Ontario is just one manifestation of a housing affordability crisis that has been deepening for 30 years across the country. It is a crisis that is particularly acute in Ontario. Nearly half of Canada's households in core housing need reside in Ontario. Eight Ontario municipalities are amongst the top 10 municipalities across Canada with the highest percentage of households in core housing need with Toronto leading the way. With its devastating impact on our economy, COVID-19 has exacerbated this crisis and threatens to rapidly increase the number of people forced into homelessness through an inability to afford their homes and consequent evictions.

Many Ontarians are in immediate housing crisis, and the province must act on a number of fronts:

- Ontario and the federal government have signed the Canada-Ontario Bilateral Agreement under the National Housing Strategy, which is planned to deliver over $5.75 billion in housing and housing supports, of which $1.4 billion will be dedicated to the provision of a portable housing benefit for eligible tenants on waiting lists for social housing. The $1.4 billion cost, called the Canada-Ontario Housing Benefit, is shared between the provincial and federal governments.[21] [22] The pool for eligible applicants is restricted to those nearly 200,000 households across the province on waiting lists for social housing. People urgently need this money during the COVID pandemic, and it should be made available as soon as possible and double-matched by the province.

- The federal government has also made available $1 billion for affordable housing under the Rapid Housing Initiative. RHI funding will be available to "municipalities, provinces, territories, Indigenous governing bodies and organizations, and non-profit organizations" [23] and Ontario should ensure that its share is used to quickly add to the stock of affordable housing. The province should match its share of the federal funds (approximately $400 million) and it must move quickly because the federal must be used within the current fiscal year.[24]

- A further $237.7 has been made available from the Government of Canada under the Reaching Home: Canada's Homelessness Strategy as part of the emergency response to the pandemic,[25] and Ontario must help insure that its share quickly reaches communities that need it.

- Many tenants are facing eviction due to pandemic-induced inability to pay rent. Ontario had a moratorium on evictions during the pandemic, but that moratorium has been lifted. It should be re-imposed.[26]

### 7. The opioid overdose crisis

**Recommendation:**

*V. a. Commit to approval and funding for Consumption and Treatment Service (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 and has worsened during the pandemic; people are dying of overdoses at the rate of five per day. There are many causes of this overdose crisis, 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 1,509 in 2019,[27] with Ontario's January to June 2019 age-adjusted rate per 100,000 of 12.2 exceeding the national average of 10.8, and only exceeded by the Yukon, BC and Alberta.[28] 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,[29] of which only 16 are currently operational. Existing facilities are under-staffed and many communities are underserviced or unserviced. Lives are being lost and that is never acceptable.

## 8. Indigenous Health

**Recommendation:**

*W. Fund a multi-year project to develop, disseminate, implement and evaluate best practice guidelines meeting the health and wellness needs of Indigenous communities, including mental health and addictions.*

RNAO strongly supports achieving optimal health and wellbeing of Indigenous communities using strength-based approaches, in addition to wise and evidence-based practices.

RNAO proposes that the Ontario government support a multi-year initiative for the development, dissemination, implementation and evaluation of best practice guidelines to meet the health and wellness needs of Indigenous communities, including mental health and addictions.

By collaborating with Indigenous leadership organizations to identify strategic priorities to address local health needs, partnerships can be created to develop models of care for Registered Nurses and/or Nurse Practitioners in Indigenous communities. RNAO has the knowledge and demonstrated experience to develop and implement best practice guidelines specifically addressing the needs of Indigenous communities across the province. Through the RNAO network of existing and new Indigenous Best Practice Spotlight Organizations (BPSO), RNAO will identify health and wellness topics for guideline development in collaboration with Indigenous leaders. Implementation support in the form of capacity building, knowledge translation and champion development have been proven over many years to be effective tools to improve patient outcomes for adults and youth within these communities.

Implementing best practice guidelines through Indigenous BPSOs is an effective initiative to address the health and wellness, mental health and addictions needs and we strongly urge the Ontario government to acknowledge and support this work.

## Appendix: Costing

### 1. Health Transformation and Ontario Health Teams

A. *Transfer funding as appropriate to ensure the 4,500 RNs currently working as care co-ordinators in LHINs are transitioned to primary care and other community-based organizations, with their contracts intact and no loss in compensation, benefits or seniority. [See same under Primary Care, below].* **Estimated cost: This should just be a transfer of payments, with minimal net effect on costs in the system. It will likely save money be making more efficient use of those RNs.**

### *2. Long-Term Care*

B. *Amend the Long-Term Care Homes Act to mandate that all LTC homes establish processes to reunite families as care partners in LTC and implement them immediately, using RNAO's Reuniting Families Guide.* **Minimal costs anticipated.**

C. *Immediately mandate and fund all long-term care homes to deliver a minimum of four worked hours of direct nursing and personal care per resident-day, including a minimum of 48 minutes of RN care, 60 minutes of RPN care and 132 minutes of PSW care.* **Estimated cost: $867,576,366 for 8,972 RN FTEs, $610,475,088 for 9,051 RPN FTEs, and $278,623,450 for 4,875 PSW FTEs. Total = $1,756,674,903.**

D. *Fund an LTC staff recruitment plan modeled after the RNAO Nursing Home Basic Care Guarantee to enable: the above four worked hours of direct care per resident-day, including a mix of RNs, RPNs and PSWs, as well as NPs; equity of compensation and benefits with the hospital sector; and, offers of full-time work.*

E. *Release the funding committed for the remaining 15 Attending NP positions of the 75 positions that were to be released in the current budget year.*[30] **Estimated cost: $7.515 M based on $114,340 per NP + 24% employment costs +overhead**.

F. *Commit funding to add 50 Attending NPs in LTC 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 for 50 ANPs per year. For 100 ANPs per year, the cost would rise to $15.03 M.**

G. *Fully support national standards for LTC homes in Canada, using RNAO's Nursing Home Basic Care Guarantee as the basis for these national standards. Ontario's support should tie federal transfer payments to the successful delivery of those standards within the jurisdiction. As we have learned from previous national initiatives, in particular in relation to health care, this is the best way to ensure that such standards are developed and implemented in a timely manner.* **Estimated cost: Dependent on standards adopted and transfer agreement.**

H. *Mandate the use of best practices for all nursing homes by supporting the insertion of RNAO's Best Practice Guidelines in Electronic Medical Records and RNAO's ongoing coaching.*

I. *Fund and direct the two-year RPN diploma programs and four-year RN nursing degree programs to incorporate a mandatory four-week practicum in an LTC setting as a part of the curriculum.* **Estimated cost**: **Equivalent to existing practicum costs.**

J. *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.* **Estimated cost: 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.**

**3. Primary Care**

K. *Fund primary care to ensure all Ontarians are linked with a primary care team, delivering 24/7 comprehensive care coordination.* **Estimated cost: This should be a net saving to the health system as it will prevent morbidity due to lack of primary care.**

L. *Fund primary care models based on the implementation of a primary health-care approach, inclusive of upstream social and environmental determinants of health.* **Estimated cost: Again, this should be a net saving to the system by reducing or delaying morbidity.**

M. *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.* **Estimated cost: This should just be a transfer of payments, with minimal net effect on costs in the system. It will likely save money be making more efficient use of those RNs. (Same as recommendation A, above).**

N. *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. <u>Home Care</u>**

O. *Increase the public funding to home care services by 20 per cent to enable increased access to home care.* **Estimated cost: 20 per cent of 2020-21 expenditure estimates of operating expenses in home care of $3,184,324,400 is $636,864,880.**

P. *Award contracts for home-care providers that can deliver a broad range of nursing and support care services 24/7 to avoid fragmented care.* **Estimated cost: Minimal expected cost, as the greater continuity of care would be the main effect.**

Q. *Award contracts with a preference for home-care agencies that are Best Practice Spotlight Organizations, as they have proven to deliver better health, clinical and satisfaction outcomes for Ontarians.* **Estimated cost: Expect net saving, as the quality and efficiency would improve.**

R. *In keeping with the Ontario Health Teams framework, ensure any dollars saved from increased integration, care coordination and better outcomes are re-invested into additional access to home care services for Ontarians and not to profit-making.* **Estimated cost: This should incent better outcomes at no extra cost to the ministry.**

**5. <u>Public Health</u>**

S. *At a minimum, maintain and extend the current level of surge funding for public health beyond the pandemic, including making permanent the 625 new public health nurse positions in Ontario schools.* **Estimated cost: $62.5 million dollars per year.**

**6. <u>Housing</u>**

T. *Invoke the following emergency measures to arrest the flow of people into homelessness*:

   a. Re-impose the provincial moratorium on evictions of those unable to pay rent; **Estimated cost: By itself, no cost unless other programs are deployed to defray the costs to landlords.**

*b. Deploy as much as possible of the $1.4 billion funding for rental support under the Canada-Ontario Housing Benefit and double Ontario's contribution of $700 million.* **Estimated cost: Ontario's share is $700 million over the period that the funding is flowed (nominally eight years), plus $700 million to double Ontario's contribution.**

U. *Work with municipalities, Indigenous governing organizations and housing associations and not-for-profit housing associations to assist with programs and funding to rapidly house people experiencing homelessness, including:*
   a. *Immediately deploy Ontario's share (about $400 million) of federal funding under the $1 billion Rapid Housing Initiative to acquire, develop and maintain affordable housing and match that with Ontario's own contribution of $400 million.*
   b. *Provide additional funds to support the provision of wrap-around services for those housed through the Rapid Housing Initiative.*
      **Estimated cost: About $400 million in RHI funds will come from the federal government, to be matched by the province.**

## 7. <u>The Opioid Overdose Crisis</u>

V. *a. Commit to approval and funding for Consumption and Treatment Service (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,[31] 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**

## 8. <u>Indigenous Health</u>

W. *Fund a multi-year project to develop, disseminate, implement and evaluate best practice guidelines meeting the health and wellness needs of Indigenous communities, including mental health and addictions.* **Estimated cost: $750,000 per year for RN/NP FTEs, guideline research and development, educational resources, knowledge translation and guideline implementation and evaluation.**

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[9] The positions were promised by the previous government. Ministry of Health and Long-Term Care. (2017). *Attending Nurse Practitioners in Long-Term Care Homes: Recruitment and Integration Toolkit. April.* http://www.health.gov.on.ca/en/pro/programs/hhrsd/nursing/docs/2017_NP_LTCH_Rec_int_toolkit.pdf.

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