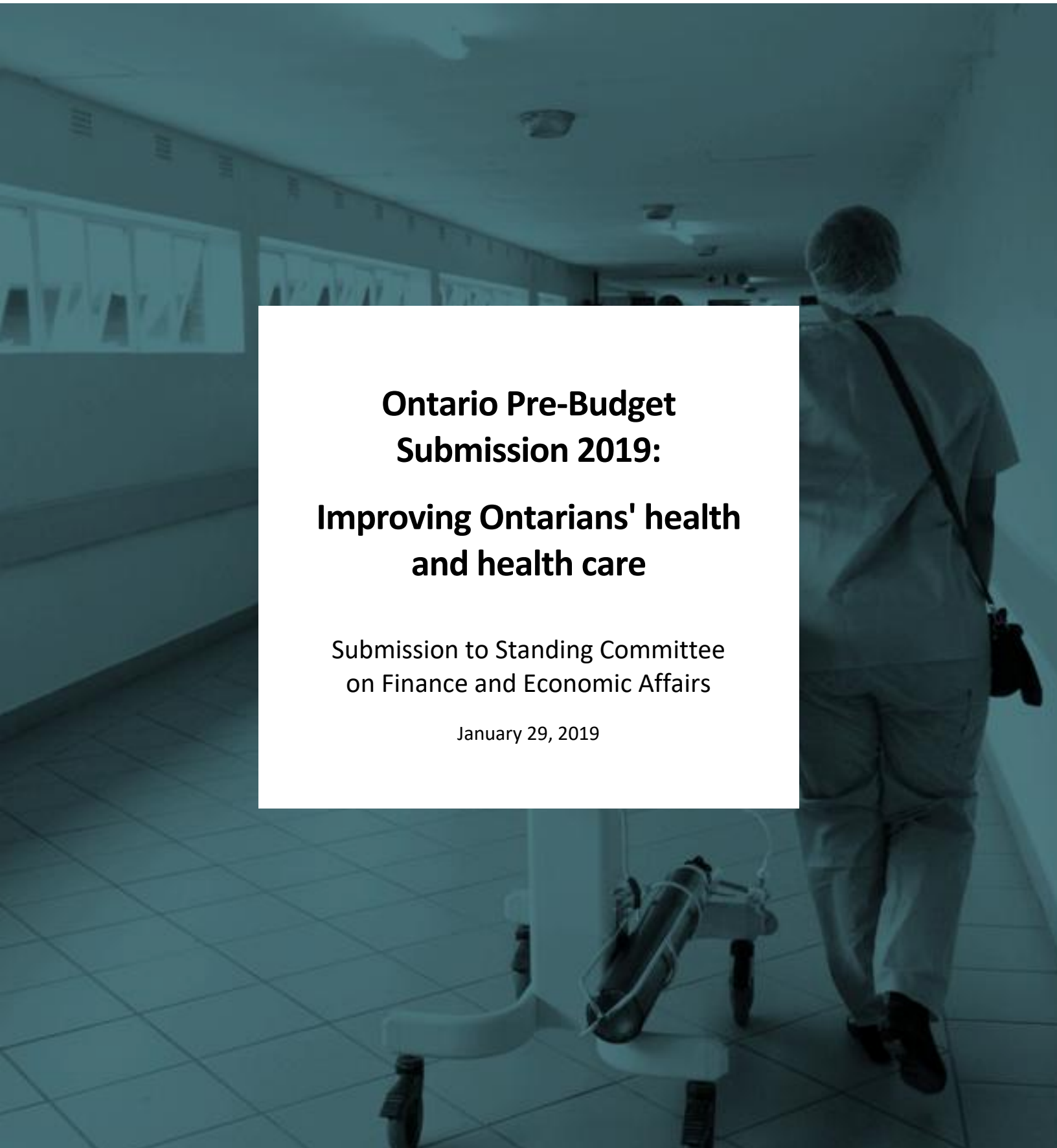
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario



Ontario Pre-Budget Submission 2019:

Improving Ontarians' health and health care

Submission to Standing Committee on Finance and Economic Affairs

January 29, 2019

Table of Content

Introduction **3**

Improving access to nursing and health care **4**

Adequate access to RN care 4
Nurse practitioner practice 6

Improving our Medicare system **7**

Long-term care 7
Oral health services for seniors living with low income 9
Patient-centred health records 9

Improving our living standards **10**

Indigenous health 10
Consumption and Treatment Services 10

Improving health through environmental protection **11**

Greenhouse gases and climate change 11
Transit and active transportation 12

Paying for these recommendations **13**

The need for revenue 13
Coming cuts in revenue and expenditure 13
Ontario has a revenue problem, not a spending problem 13

Summary of recommendations **15**

References **17**

Introduction

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 Ontarians' health and health care. RNAO welcomes this chance to speak about our province's spending priorities to the Standing Committee on Finance and Economic Affairs.

RNAO's recommendations focus on improving access to nursing and health care; strengthening our Medicare system; boosting living standards; protecting the environment; and being able to pay for these improvements by making our tax system fairer and more progressive. In the view of nurses, these are public investments that will keep Ontarians healthy and productive.

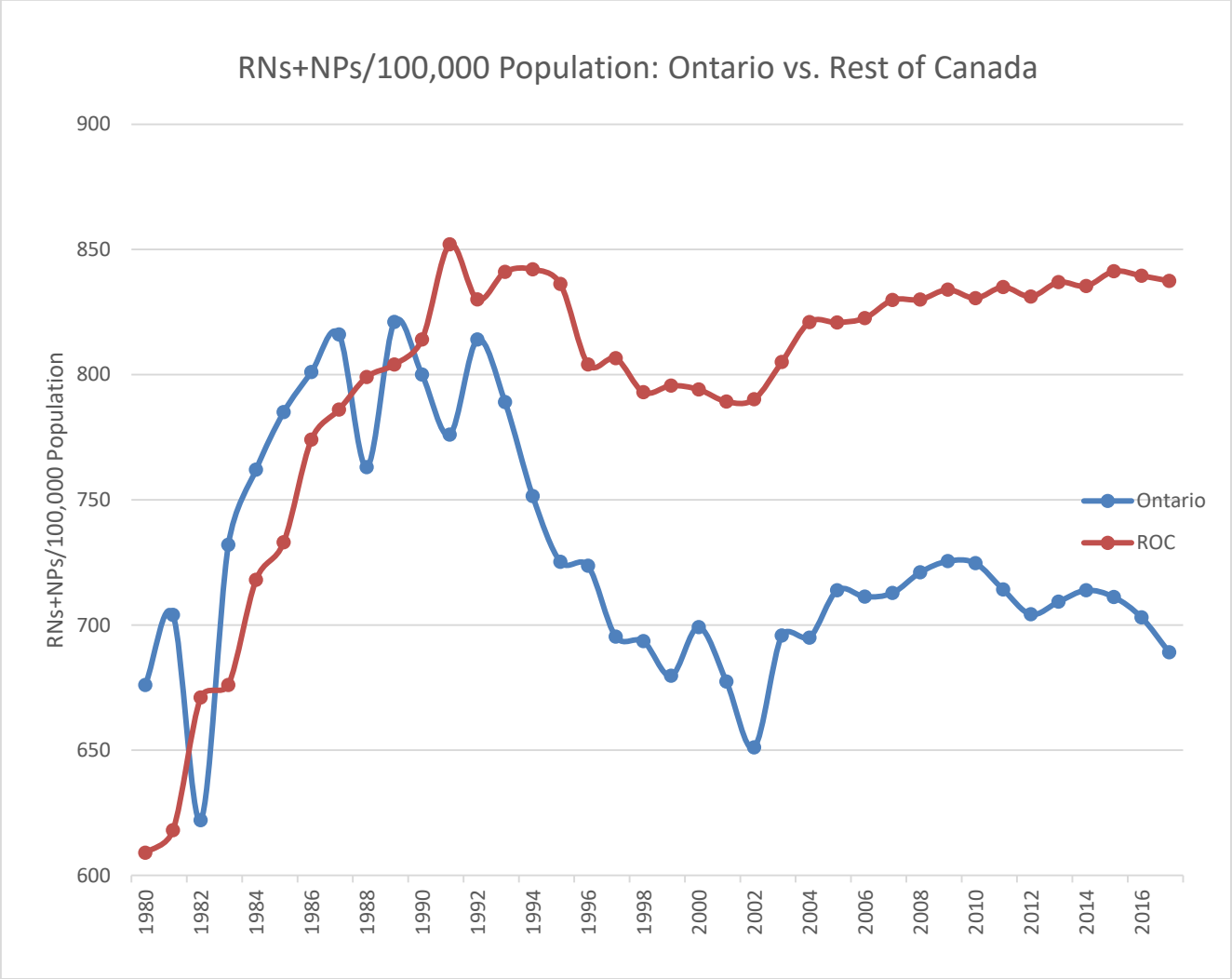
Improving access to nursing and health care

Adequate access to RN care

Ontario must fund more RN positions

Evidence shows that RNs deliver better results for lower cost.[1] The latest figures show the RN-to-population ratio in Ontario is the lowest in Canada for the third year in a row.[2] A huge and widening gap has opened up between the province and the rest of the country.[3] Ontario has only 669 RNs per 100,000 people compared to an average of 828 RNs per 100,000 people in the rest of Canada[4] and there are more than 10,000 vacant RN positions in our hospitals.[5]

Recommendation 1:
Provide hospitals with funding earmarked to immediately fill 10,000 RN vacancies.



The right nurse in the right place

In acute care and cancer care hospitals, nearly all patients need the advanced knowledge and judgment of RNs.

Recommendation 2:
Require all new nursing hires in acute care and cancer care hospitals to be RNs.

Let us be clear, we are not suggesting to lay off RPNs or PSWs. Instead what we are urging is that new hires be RNs. This is because patients are now so complex in acute care and cancer care hospitals that they require the competencies of an RN.

Since more and more patients with complex needs are being treated at home, initial home health-care visits should be provided by RNs because they have the knowledge, skill, and judgment to ensure a patient's complex needs are met safely.[6]

Recommendation 3:
Require all first home care assessments be conducted by an RN.

Our health system is more than hospitals and home care. In fact, no health system is strong without a robust primary care sector – a hallmark of a high-functioning health care system. Now that Community Care Access Centre (CCAC) functions have been transferred to the Local Health Integration Networks (LHIN), RNAO wants the government to relocate the 4,500 former RN CCAC care co-ordinators (this number excludes those working in hospitals) into primary care settings; to be employed by the LHINs with salary and benefits intact. Moving care co-ordination and RN care co-ordinators to primary care will expand the reach of primary care practitioners into community care. This shift will enhance timely access to care, facilitate seamless transitions of care for patients and families, reduce duplication, increase quality of care, and reduce costs.[7]

Recommendation 4:
Relocate the 4,500 RN care co-ordinators currently in LHINs to primary care.

RN prescribing

An additional way to enhance timely access to care is to enable RNs to order diagnostics for non-complex conditions so that they can diagnose common ailments such as urinary tract infections and sore throats. RNAO urges prompt implementation of independent RN prescribing as the best model to improve timely access to care.[8] Independent RN prescribing has been successfully used for over a decade in the United Kingdom,[9] and many other countries.[10]

Of grave concern, proposed regulation changes[11] approved by the College of Nurses of Ontario (CNO) Council in Dec. 2018 severely restrict RN prescribing to a limited list of drugs and drug categories. Thus, RNAO's recommendation is that the Ford government do what's right for the people and:

Recommendation 5:
Implement independent RN prescribing in all sectors, inclusive of diagnostic tests by 2019, and integrate RN prescribing into the curriculum for baccalaureate nursing by 2020.

Psychotherapy

We also ask our government to keep its strong interest in people experiencing mental health challenges and who are being seen by various health professionals including RNs.

Recommendation 6:
Ensure RNs are allowed to continue to initiate and perform the controlled act of psychotherapy.

Nurse practitioner practice

Nurse practitioner compensation

RNAO represents over 42,000 RNs, NPs and nursing students. In fact, RNAO represents the largest number of Nurse Practitioners (NP) in Ontario. Nurse Practitioners (NP) are registered nurses who have a broader scope of practice based on advanced education, knowledge and skills.[12] Evidence from the last 40 years makes it clear that greater use of NPs enhances timely access to care across all sectors, and in particular, in primary care. But while recent Ontario budgets earmarked more funding for primary care, little of that was spent on NPs. That needs to change. The health ministry should designate extra funding specifically for NPs to ensure they are compensated adequately and equitably, based on their role regardless of which sector they work in.

Recommendation 7:
Dedicate additional funds to ensure that new and existing NPs in primary care receive compensation equivalent to that received by NPs in hospitals.

Legislative, regulatory and organizational barriers to NP practice

Patients and Ontario's health-care system have much to gain by enabling NPs to practise to their full scope, but that will not happen until the government implements needed regulatory and legislative changes and until it directs health-care institutions to remove barriers that prevent those changes from taking effect. Ontario has yet to proclaim or make effective changes in the *Regulated Health Professions Statute Law Amendment Act, 2009*[13] that expanded that scope of NPs so they could perform point-of-care tests, order diagnostic scans, apply specified forms of energy, and more.[14]

In addition, while NPs are legislatively authorized to serve as the primary provider for patients in primary care settings, hospitals, and long-term care facilities, this function has not been fully embraced by the hospital sector. As such, NPs have not been designated as Most Responsible Provider (MRP) in our hospitals, a failure that restricts access to timely and quality care and squanders the contributions NPs are eager and fully competent to deliver.

Recommendation 8:
Remove legislative, regulatory, and practice environment barriers to NPs' scope of practice, as follows:

- **Ensure NPs are enabled to act as most responsible providers in hospital.**
- **Authorize NPs to perform point-of-care testing.**
- **Authorize NPs to order additional forms of energy (e.g., CT, MRI, nuclear medicine procedures, non-invasive EEGs, and ECGs in all situations).**
- **Authorize NPs to apply specified forms of energy (e.g., defibrillation).**
- **Expand NPs' authority to certify a death.**
- **Authorize NPs to complete Forms 1, 2, 3, 4, 5, 14 and 28 for mental health services under the Mental *Health Act*.**

Improving our Medicare system

Long-term care

Long-term care funding models

Despite the growing incidence of responsive behaviours, a term used to describe the behavioural and psychological symptoms of dementia,[15] and despite increasingly complex needs of long-term care (LTC) residents, Ontario has not improved its funding and staffing model. As a result, it is not surprising that we hear about increased reports of violence in LTC homes.[16] [17] [18] [19] [20] Ontario must change how it funds LTC so homes are better able to provide safe care to residents. The government also must stop penalizing homes whose practices improve patient outcomes and thus lower acuity.[21]

Recommendation 9:
Transform funding models in LTC to account for complexity of resident care needs and quality outcomes. LTC homes that improve residents' outcomes due to evidence-based care and decrease acuity should retain all funding to reinvest in additional staffing for residents.

Long-term care best practices

Under regulations in the *Long-Term Care Homes Act* (LTCHA), homes must implement evidence-based practices to provide quality care for residents. [22] [23] RNAO has developed best practice guidelines (BPG) that address each of the mandatory programs that LTC homes must implement, and other BPGs relevant to the LTC setting, including: falls prevention; wound care; managing delirium, dementia, and

depression; alternates to restraints; and preventing and addressing abuse and neglect. It is imperative to support evidence-based practices in LTC homes, such as RNAO's Long-Term Care Best Practices Program (BPG) and co-ordinators, so we can promote and sustain improvements in resident health and well-being.

Recommendation 10:
Mandate the implementation of relevant RNAO BPGs when MOHLTC inspectors find homes are non-compliant.

Long-term care staffing

Disturbingly, Ontario legislation only requires that LTC be staffed with the vague instruction to "meet the assessed needs of residents"[24] and a minimum requirement of one registered nurse (RN) on duty at all times.[25] The previous government committed to increasing staffing levels in LTC to ensure a provincial average of four hours of direct nursing, personal, and therapeutic care in the target average number of hours.[26] RNAO believes that every home should meet this minimum and that therapeutic care should be in addition to these four hours, with more hours for residents with greater acuity. This new benchmark would still fall short of what is needed to meet quality standards as set by the US Centers for Medicare and Medicaid Services, which found that a minimum of 0.75 hours per resident day of RN care and 4.1 hours of nursing and personal care per day were necessary.[27]

Recommendation 11:
Legislate a minimum of four hours of nursing and personal care per resident per day in long-term care.

Recommendation 12:
Legislate minimum nursing and personal care staffing and skill mix standards in LTC, accompanied by the necessary funding to support these changes. We call for no less than one attending NP for every 120 residents,[28] [29] and a skill mix of RNs, RPNs, and unregulated care providers consisting of at least 20 per cent RNs, 25 per cent RPNs, and no more than 55 per cent PSWs. This ratio would advance safe and quality care.

Attending NPs in LTC

RNAO successfully advocated for the creation of the attending NP role in LTC so that the needs of residents are met in a timely way. Attending NPs manage and co-ordinate care in their respective LTC homes. The role has resulted in reduced hospitalization by detecting and treating medical complications early, managing chronic conditions, and dedicating time for health promotion and overall staff education.

While the MOHLTC announced in 2015 funding for 75 attending NPs in LTC positions,[30] only 49 are in place and only 60 funded. LTC homes and their residents are in desperate need for the remaining

positions to be funded and filled. Despite RNAO's numerous queries, we remain unclear as to when all the positions will be funded and filled.

Recommendation 13:
Release funding for the outstanding attending NP in LTC positions. Hold LTC homes accountable for hiring attending NPs in the manner specified by the MOHLTC role description and funding policy.

Oral health services for seniors living with low income

Oral health is a critical component of overall health and well-being.[31] Serious health conditions linked to poor oral health include cardiovascular disease, respiratory infections, diabetes, and poor nutrition.[32] Oral health problems resulting in damaged and/or missing teeth can be associated with loss of self-esteem, social isolation, and diminished employment prospects.[33 34 35 36 37]

RNAO looks forward to the government delivering on its campaign promise – to assist up to 100,000 low-income seniors each year with access to dental services through a $98 million per year investment.[38] RNAO encourages the government to move swiftly and implement the promised second stage of investments "in new dental services in underserviced areas, including increasing capacity in public health units and investing in mobile dental buses."[39]

Recommendation 14:
Expedite the implementation of a new program of dental care for low income seniors by increasing funding for dental services in community health centres, Aboriginal health access centres, and public health units. Provide a clear timeline to invest in new public dental services in underserviced areas, including the use of mobile dental buses.

Patient-centred health records

A key component of person-centred care is to put patients in control of their own health records.[40] A personal health record will help patients and/or their designated decision-makers to make informed choices and improve management of their health care.[41] Evidence shows that when patients have access to their health information, they are more engaged, more informed and more satisfied.[42 43]

RNAO recommends using the following principles to guide the development of a personal health record (PHR) system for Ontario:

- **Patient-controlled** – the PHR is viewable and editable by patients, and designated families or caregivers when appropriate.
- **Trustworthy** – personal health information is accurate, up-to-date, secure, and private.
- **Comprehensive** – integrates information from patients, electronic medical records, and clinical reports from all health sectors (including hospitals, community, labs and pharmacies).

- **Accessible** – available at all times, from any location,[44] with real time updates. Tutorials provided to make PHR easy to use for all who choose to.
- **Publicly-funded and administered** – no out-of-pocket expenses.
- **Rigorously evaluated**, with system-wide results transparently shared.

Recommendation 15:
Develop and maintain a strategy to make PHRs available to all patients after consulting with patients, families, caregivers, RNs, NPs, and other health providers.

Improving our living standards

Indigenous health

It is imperative that the government provide resources and supports to Indigenous communities so they can deliver evidence-based, culturally appropriate, safe health interventions. Over the past year, RNAO has worked alongside Ontario Indigenous leaders, nurses and other health providers as well as community members to co-create the *RNAO Supporting Health Interventions in Indigenous Communities* program that is built upon the principles of cultural safety, health equity and Indigenous knowledge and values. Grounded in the social determinants of health, the program provides resources for equitable access to health supports for communities across Ontario. The program has three steps: a) Develop an Indigenous Partner Reference Group to provide guidance and support on program development, evaluation and sustainability; b) Create a best practice guideline on topics determined to be important by Indigenous communities (i.e., substance use, prevention of suicide, diabetes prevention, etc.); and c) Establish a tailored Best Practice Spotlight Organization (BPSO) Designation for Indigenous communities and health organizations.

By working alongside and supporting Indigenous communities in their efforts for self-determination and health-system transformation, we can together address some of the mental, physical, social and economic health inequities experienced by Indigenous communities.

Recommendation 16:
Continue to fund RNAO to strengthen its partnerships with Indigenous communities to co-create clinical best practice guidelines and to expand the Indigenous-focused Best Practice Spotlight Organizations to address the health needs of Indigenous persons.

Consumption and Treatment Services

According to figures from the Ontario government, there were at least 1,265 deaths across the province in 2017 attributed to opioid poisoning.[45] That's an increase of 45 per cent from the previous

year when 867 deaths were recorded.[46] This means that more than three Ontarians died each day from opioid overdose.[47] Supervised injection services (SIS) and overdose prevention services (OPS) help keep people alive. In addition to reviving people with oxygen and/or naloxone, these services help health professionals and outreach workers build relationships with people who use drugs. These relationships, formed in a non-judgmental and compassionate way, help those at risk from opioids to access care, treatment, and rehabilitation, if and when they are ready to do so.[48] [49]

After an extensive review[50] [51] [52] of SIS effectiveness,[53] [54] [55] Health Minister Christine Elliott announced that "Consumption and Treatment Services (CTS) would replace the former Supervised Consumption Services and Overdose Prevention Site models."[56] When the CTS program was announced, Minister Elliott stated that the province "wants to see no more than 21 overdose prevention sites in operation in Ontario."[57] [58] The challenge is that this cap is already met by the 16 SIS/OPS sites currently operating, the three sites that were put on hold, and two permanent SIS sites that were approved on October 31 in London.[59] In the midst of an unrelenting crisis, RNAO wants to ensure there are enough people and resources to reach all of those in need across this vast province.[60]

Recommendation 17:
Expedite the authorizing and funding of Consumption and Treatment Services (CTS) across the province where they are needed to save lives.

- **Immediately increase access to CTS to all communities in need.**
- **Streamline and expedite the CTS application process to increase access to this life-saving health service.**
- **Invest sufficient funding in the CTS program to help prevent deaths from overdose. In addition, provide funding and support for the treatment services required by the CTS model because there is now a shortage of treatment, recovery and mental health and addiction services.**

Improving health through environmental protection

Greenhouse gases and climate change

Climate change is real and caused by human emissions of greenhouse gases (GHG). It is already affecting the health of Ontarians. On Nov. 29, 2018 the Ontario government released its environment and climate change plan, setting a greenhouse gas (GHG) target of 30 per cent below 2005 levels by 2030.[61] As the Environmental Commissioner of Ontario pointed out, this represented a two-thirds reduction in Ontario's previous 2030 target,[62] which was 37 per cent below 1990 levels.[63] In addition, the government has regressed on climate and environmental issues as follows: It repealed Ontario's cap-and-trade regime via Bill 4,[64] cut the gas tax,[65] repealed the *Green Energy Act* via Bill 34,[66] [67] ended

Drive Clean, cancelled 758 renewable energy projects,[68] and introduced Bill 66,[69] which would allow municipalities to override prescribed protections of the *Clean Water Act,* the *Greenbelt Act,* the *Great Lakes Protection Act,* and *Lake Simcoe Protection Act,* among others.[70] It would also repeal the *Toxics Reduction Act.*

Recommendation 18:
Develop a climate change plan that, at a minimum, meets Ontario's legislated GHG reduction targets of 15 per cent below 1990 levels by 2020, 37 per cent by 2030 and 80 per cent by 2050.

Transit and active transportation

Automobiles are a major source of pollution, particularly in urban environments. They also cause congestion on our roadways, which costs Ontarians billions of dollars in time, vehicle operating costs, accidents, emissions, and lost economic opportunities.[71] Yet many people in urban areas have no choice but to drive, with public transit options inadequate and opportunities for active transportation (cycling and walking) either undeveloped or unsafe.

The government has maintained commitments to a number of transit projects and proposes adding $5 billion in new subway funding. In our view, three of the four proposed projects (Toronto's Scarborough subway, Sheppard and Eglinton Crosstown) do not have the ridership to justify the cost. We are also of the view that the committed funding is inadequate to deliver the promised infrastructure.[72] Lastly, the severity of the government's proposed revenue cuts (e.g., $2 billion per year from cap-and-trade) raises the question of whether transit commitments can be met.

Recommendation 19:
Take all necessary steps to:

- **Work with federal and municipal partners to ensure dedicated and sustainable revenue sources to pay for ongoing operation and substantial expansion of transit and active transportation in Ontario.**
- **Support cost-effective and expeditious delivery of those expansions, implemented by transparent governance and informed expert opinion.**
- **Don't fund transit expansion by selling public assets such as Hydro One.**

Paying for these recommendations

The need for revenue

Taxes and other government revenues pay for the public services required in a civilized and healthy society – including health care, education, social services, environmental protection and public security. They also pay the wages of workers who deliver those services, including nurses and other health professionals.

Coming cuts in revenue and expenditure

Since the June 7, 2018 election, the Ford government has said it will shrink the size of government. That means Ontarians will have less access to public services. Given that the government has undertaken to eliminate the deficit, there will be a significant gap to be filled. The PC platform would increase the deficit by $10.4 billion, and in the absence of new revenue, program spending would have to fall by more than $10.4 billion in order to reduce the deficit as promised. [73] That estimate may grow. For example, while the government foregoes $1.9 billion in annual revenue from ending the cap-and-trade carbon pricing program, it may also face claims from greenhouse gas emitters who had already paid over $2.8 billion as of May 2018 and who might seek to recover their money from the government.

Ontario has a revenue problem, not a spending problem

Although Ontario has a higher per capita GDP than six of the nine other provinces,[74] its per capita program expenditures are the second lowest in Canada, after Quebec (which can afford much less, as it has a much lower per capita GDP).[75] And when one takes into account the availability of resources (GDP), the depth of the austerity is evident: Ontario's program spending-to-GDP ratio at 16.4 per cent for 2016-17 was lower than all other provinces and territories. Five of the other provinces were well over 20 per cent.[76] Ontario also has had the lowest or second-lowest revenue-to-GDP ratio of the Canadian provinces since 1981-82, so Ontario has opted to keep its revenue collection low by Canadian standards. The reason Ontario has run a deficit for years is that it collects even less revenue than it spends. The resulting debt (39.5 per cent of GDP in 2016-17) is the fourth highest in Canada. More revenue is needed both for programs and to reduce the deficit.

There are many revenue options. Green taxes, such as emission taxes or emission charges, have the advantage of discouraging harmful behaviour by making it more expensive. These taxes are more efficient, and can generate revenue and replace less efficient taxes, such as payroll taxes that discourage employment.

Recommendation 20:
Build a more progressive tax system and don't cut taxes so Ontario develops the fiscal capacity to deliver all essential health, health care, social, and environmental services.

Recommendation 21:
Make polluters pay for the full cost of the pollution they create, including their carbon emissions. Support the national carbon pricing initiative. Increase revenue sources in ways that are fair and equitable, and that encourage environmental and societal responsibility.

RNAO welcomes this chance to provide its feedback to the Standing Committee on Finance and Economic Affairs. Our focus on improving access to nursing and health care; strengthening our Medicare system; boosting living standards; protecting the environment; and being able to pay for these improvements by making our tax system more progressive, are in the view of nurses - public investments that will keep Ontarians healthy and productive.

Summary of recommendations

1. Provide hospitals with funding earmarked to immediately fill 10,000 RN vacancies.
2. Require all new nursing hires in acute care and cancer care hospitals to be RNs.
3. Require all first home care assessments be conducted by an RN.
4. Relocate the 4,500 RN care co-ordinators currently in LHINs to primary care.
5. Implement independent RN prescribing in all sectors, inclusive of diagnostic tests by 2019, and integrate RN prescribing into the curriculum for baccalaureate nursing by 2020.
6. Ensure RNs are allowed to continue to initiate and perform the controlled act of psychotherapy.
7. Dedicate additional funds to ensure that new and existing NPs in primary care receive compensation equivalent to that received by NPs in hospitals.
8. Remove legislative, regulatory, and practice environment barriers to NPs' scope of practice as follows:
    - Ensure NPs are enabled to act as most responsible providers in hospital.
    - Authorize NPs to perform point-of-care testing.
    - Authorize NPs to order additional forms of energy (e.g., CT, MRI, nuclear medicine procedures, non-invasive EEGs, and ECGs in all situations).
    - Authorize NPs to apply specified forms of energy (e.g., defibrillation).
    - Expand NPs' authority to certify a death.
    - Authorize NPs to complete Forms 1, 2, 3, 4, 5, 14 and 28 for mental health services under the Mental *Health Act*.
9. Transform funding models in LTC to account for complexity of resident care needs and quality outcomes. LTC homes that improve residents' outcomes due to evidence-based care and decrease acuity should retain all funding to reinvest in additional staffing for residents.
10. Mandate the implementation of relevant RNAO BPGs when MOHLTC inspectors find homes are non-compliant.
11. Legislate a minimum of four hours of nursing and personal care per resident per day in long-term care.
12. Legislate minimum nursing and personal care staffing and skill mix standards in LTC, accompanied by the necessary funding to support these changes. We call for no less than one attending NP for every 120 residents, and a skill mix of RNs, RPNs, and unregulated care providers consisting of at least 20 per cent RNs, 25 per cent RPNs, and no more than 55 per cent PSWs. This ratio would guarantee LTC residents receive care when they need it from the most appropriate provider.
13. Release funding for the outstanding attending NP in LTC positions. Hold LTC homes accountable for hiring attending NPs in the manner specified by the MOHLTC role description and funding policy.

14. Expedite the implementation of a new program of dental care for low income seniors by increasing funding for dental services in community health centres, Aboriginal health access centres, and public health units. Provide a clear timeline to invest in new public dental services in underserviced areas, including the use of mobile dental buses.

15. Develop and maintain a strategy to make personal health records available to all patients after consulting with patients, families, caregivers, RNs, NPs, and other health providers.

16. Continue to fund RNAO to strengthen its partnerships with Indigenous communities to co-create clinical best practice guidelines and to expand the Indigenous-focused Best Practice Spotlight Organizations to address the health needs of Indigenous persons.

17. Expedite the authorizing and funding of Consumption and Treatment Services (CTS) across the province where they are needed to save lives.

    - Immediately increase access to CTS to all communities in need.
    - Streamline and expedite the CTS application process to increase access to this life-saving health service.
    - Invest sufficient funding in the CTS program to help prevent deaths from overdose. In addition, provide funding and support for the treatment services required by the CTS model because there is now a shortage of treatment, recovery and mental health and addiction services.

18. Develop a climate change plan that, at a minimum, meets Ontario's legislated GHG reduction targets of 15 per cent below 1990 levels by 2020, 37 per cent by 2030 and 80 per cent by 2050.

19. Take all necessary steps to:

    - Work with federal and municipal partners to ensure dedicated and sustainable revenue sources to pay for ongoing operation and substantial expansion of transit and active transportation in Ontario.
    - Support cost-effective and expeditious delivery of those expansions, implemented by transparent governance and informed expert opinion.
    - Don't fund transit expansion by selling public assets such as Hydro One.

20. Build a more progressive tax system and don't cut taxes so Ontario develops the fiscal capacity to deliver all essential health, health care, social, and environmental services.

21. Make polluters pay for the full cost of the pollution they create, including their carbon emissions. Support the national carbon pricing initiative**.** Increase revenue sources in ways that are fair and equitable, and that encourage environmental and societal responsibility.

References

[1] Registered Nurses' Association of Ontario (RNAO). (2017). *70 years of RN effectiveness.* http://rnao.ca/bpg/initiatives/RNEffectiveness.

[2] RNAO. (2018). *Ontario has the worst RN-to-population ratio in Canada: Province must hire more RNs to end hallway nursing* [Media Release]. https://rnao.ca/news/media-releases/2018/06/14/ontario-has-worst-rn-population-ratio-canada-province-must-hire-more-.

[3] RNAO. (2018). *RN/NP Workforce Backgrounder.* p. 27. https://rnao.ca/sites/rnao-ca/files/RNAO_RN_NP_HR_Backgrounder_April_2018.pdf.

[4] RNAO. (2018). *Ontario has the worst RN-to-population ratio in Canada: Province must hire more RNs to end hallway nursing* [Media Release]. https://rnao.ca/news/media-releases/2018/06/14/ontario-has-worst-rn-population-ratio-canada-province-must-hire-more-.

[5] RNAO & ONA. (2018). *Ontarians need more registered nurses* [Backgrounder]. May. http://rnao.ca/sites/rnao-ca/files/RNAO_ONA_Backgrounder_May72018.pdf.

[6] RNAO. (2016). *Mind the safety gap in health system transformation: Reclaiming the role of the RN*. http://rnao.ca/sites/rnao-ca/files/HR_REPORT_May11.pdf.

[7] Ontario Primary Care Council. (2016). *Framework for primary care in Ontario*. http://www.afhto.ca/wp-content/uploads/OPCC-Framework-for-Primary-Care-2016-01-13.pdf.

[8] A fuller description of RNAO's position on RN prescribing may be found at: Registered Nurses' Association of Ontario. (2018). *Reclaiming the role of the RN.* Pp. 5-6. https://qpor.rnao.ca/sites/default/files/Reclaiming%20the%20role%20of%20the%20RN_QPOR%202018_public.pdf.

[9] Royal College of Nursing. (2012). *RCN Fact Sheet: Nurse Prescribing in the UK.* https://www.rcn.org.uk/about-us/policy-briefings/pol-1512.

[10] Registered Nurses' Association of Ontario. (2016). *Registered Nurse Prescribing Referral – Submission to the Health Professions Regulatory Advisory Council*. https://rnao.ca/sites/rnao-ca/files/RNAO_RN_Prescribing_HPRAC_-_Jan_15_2016_Submission-Final.pdf

[11] College of Nurses of Ontario. (2018). *Clause by clause overview of draft regulation under the Nursing Act, 1991.* December. http://www.cno.org/globalassets/1-whatiscno/legislation/clause-by-clause-regulation-overview.pdf.

[12] College of Nurses of Ontario. (2016). *Nurse practitioners*. http://www.cno.org/en/learn-about-standards-guidelines/educational-tools/nurse-practitioners/.

[13] Regulated Health Professions Statute Law Amendment Act (2009, c. 26). https://www.ontario.ca/laws/statute/s09026

[14] College of Nurses of Ontario (CNO). (2018). FAQs: Bill 179. http://www.cno.org/en/what-is-cno/regulation-and-legislation/legislation-governing-nursing/faq-bill-179/

[15] Responsive behaviours is a term to describe the behavioural and psychological symptoms of dementia, which includes, to varying levels of severity, changes in mood, delusions, apathy, agitation, wandering, calling out, repetitive questioning, and sexual disinhibition. Source: RNAO. (2016). *Delirium, dementia, and depression in older adults: Assessment and care (2nd*

ed.). http://rnao.ca/sites/rnao-ca/files/bpg/RNAO_Delirium_Dementia_Depression_Older_Adults_Assessment_and_Care.pdf.

[16] Anon. (2017, May 16). Grey matters: Mistreatment and abuse of patients in long-term care homes is anything but rare. *National Post.* http://nationalpost.com/news/canada/grey-matters-mistreatment-and-abuse-of-patients-in-long-term-care-homes-is-anything-but-rare/wcm/b1ac28f5-2473-4014-b22d-92076a8804ef.

[17] Helmer, A. (2017, July 27). Union calls long-term care violence 'tragic symptom of a care system in crisis'. *Ottawa Citizen.* http://ottawacitizen.com/news/local-news/union-calls-long-term-care-violence-tragic-symptom-of-a-care-system-in-crisis.

[18] Fraser, L. (2017, January 31). 82-year-old faces manslaughter charge in the death of fellow long-term care resident. *CBC News.* http://www.cbc.ca/news/canada/toronto/senior-manslaughter-long-term-care-death-1.3960786.

[19] Anon. (2016, January 5). Wave of dementia behind 12 homicides has Ontario nursing homes pleading for help from province. *National Post.* http://nationalpost.com/news/canada/wave-of-dementia-behind-12-homicides-has-ontario-nursing-homes-pleading-for-help/wcm/a9780387-df1b-41a6-9be4-69f918b3d2b4.

[20] Geriatric and Long Term Care Review Committee. (2016). *2015 annual report*. http://www.mcscs.jus.gov.on.ca/sites/default/files/content/mcscs/docs/GLTRC%202015%20annual%20report%20ENGLISH.pdf.

[21] For a more detailed discussion, see RNAO. (2018). *Transforming long-term care to keep residents healthy and save.* p. 3. https://qpor.rnao.ca/sites/default/files/Transforming%20long-term%20care_QPOR%202018_public.pdf.

[22] O. Reg. 79/10, s. 30.

[23] O. Reg. 79/10, s. 48.

[24] *Long-Term Care Homes Act*, 2007, S.O. 2007, c. 8, s. 8(1) Every licensee of a long-term care home shall ensure that there is, (a) an organized program of nursing services for the home to meet the assessed needs of the residents; and (b) an organized program of personal support services for the home to meet the assessed needs of the residents.

[25] *Long-Term Care Homes Act*, 2007, S.O. 2007, c. 8, s. 8 (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

[26] Government of Ontario. (2017). *Aging with Confidence: Ontario's action plan for seniors.* https://files.ontario.ca/ontarios_seniors_strategy_2017.pdf.

[27] U.S. Centers for Medicare and Medicaid Services, Abt Associates Inc. (2001). *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final. Volumes I–III.* Baltimore, MD: CMS. Referenced in Harrington, C. Schnelle, J.F., McGregor, M. and Simmons, S.F. (2016). The Need for Higher Minimum Staffing Standards in :U.S. Nursing Homes. *Health Services Insights.* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4833431/#b17-hsi-9-2016-013.

[28] MOHLTC.(2015). *Policy: Attending nurse practitioners in long-term care homes initiative funding policy.* http://www.health.gov.on.ca/en/public/programs/ltc/docs/attending_nps_in_ltch_policy.PDF.

[29] MOHLTC. (2017). *Attending nurse practitioners in long-term care homes. Recruitment and integration toolkit*. Toronto: Author.

[30] Ministry of Health and Long-Term Care. (2015). *75 New Nurse Practitioners to be Hired in Long-Term Care Homes.* September 24. https://news.ontario.ca/mohltc/en/2015/09/75-new-nurse-practitioners-to-be-hired-in-long-term-care-homes.html.

[31] RNAO. (2008). *Oral health: Nursing assessment and intervention.* http://rnao.ca/bpg/guidelines/oral-health-nursing-assessment-and-intervention.

[32] King, A. (2012). *Oral health--More than just cavities: A report by Ontario's Chief Medical Officer of Health.* Toronto: Ministry of Health and Long-Term Care, 7. http://www.health.gov.on.ca/en/common/ministry/publications/reports/oral_health/oral_health.pdf.

[33] Watt, R., Listl, S., Peres, M. & Heilmann, A. (2015). *Social inequalities in oral health: From evidence to Action.* London: International Centre for Oral Health Inequalities Research & Policy, 6. http://media.news.health.ufl.edu/misc/cod-oralhealth/docs/posts_frontpage/SocialInequalities.pdf.

[34] Al-Sudani, F., Vehkalahti, M., & Suominen, A. (2015). The association between current unemployment and clinically determined poor oral health. *Community Dentistry and Oral Epidemiology*. 43(4): 325-337.

[35] Moeller, J., Singhal, S., Al-Dajani, M., Gomaa, N., & Quinonez, C. (2015). Assessing the relationship between dental appearance and the potential for discrimination in Ontario, Canada. *SSM-Population Health*. 1: 26-31.

[36] Welsh, M. (2007, February 10). Why is he out of work? *Toronto Star*. https://www.thestar.com/news/2007/02/10/why_is_he_out_of_work.html.

[37] Hunter, P. (2017, October 30). A decade later, Jason Jones still smiling thanks to generosity of Star readers. *Toronto Star.* https://www.thestar.com/anniversary/2017/10/30/a-decade-later-jason-jones-still-smiling-thanks-to-generosity-of-star-readers.html.

[38] Ontario PC Party. (2018). *Doug Ford will invest in dental care for low-income seniors.* https://www.ontariopc.ca/doug_ford_will_invest_in_dental_care_for_low_income_seniors.

[39] Ibid.

[40] A caregiver is a person who takes on an unpaid caring role for someone who needs help because of a physical or cognitive condition, an injury, or a chronic life-limiting illness. Definition: Carers Canada at http://www.carerscanada.ca/carer-facts/.
[41] Archer, N., Fevrier-Thomas, U., Lokker, C., McKibbon, K.A. & Straus, S.E. (2011). Personal health records: a scoping review. *Journal of the American Medical Informatics Association, 18,* 515-522.
[42] Nazi, KM., Turvey, CL., Klein, DM., Hogan, TP. & Woods, SS. (2015). VA OpenNotes: exploring the experiences of early patient adopters with access to clinical notes. *Journal of the American Medical Informatics Association, 22*, 380.
[43] Curtis, J., Cheng, S., Rose, K. & Tsai, O. (2011). Promoting adoption, usability, and research for personal health records in Canada: The MyChart experience. *Healthcare Management Forum, 24,* 149.

[44] The increased mobility of patients and care providers requires that electronic PHRs can be accessed anytime, anywhere – ideally through a web-based application.

[45] Public Health Ontario (2018, September 13). Opioid-related morbidity and mortality in Ontario. https://www.publichealthontario.ca/en/dataandanalytics/pages/opioid.aspx
[46] Toronto Public Health (2018). *Toronto overdose action plan: Status report 2018*. Report from the Medical Officer of Health to the Board of Health, 2. https://www.toronto.ca/legdocs/mmis/2018/hl/bgrd/backgroundfile-116008.pdf.

[47] Delamont, K. (2018, May 27). Opioid overdose deaths surpass 1,200 in Ontario for 2017, new data show. *Ottawa Citizen.* https://ottawacitizen.com/news/local-news/opioid-overdose-deaths-surpass-1200-in-ontario-for-2017-new-data-show.

[48] Kearsey, K. (2011, March-April). The Fix: RNs offer harm reduction services as the first line of defence against a life of addiction. *Registered Nurse Journal*, 24-25.

[49] University of British Columbia, School of Population and Public Health (2017, February 28). Meet people where they are: Harm reduction and the opioid crisis in British Columbia. http://www.spph.ubc.ca/meet-people-where-they-are-harm-reduction-and-the-opioid-crisis-in-british-columbia/

[50] Canadian Press. (2018, July 24). Fate of Ontario safe injection and overdose prevention sites in limbo. *Toronto Star.* https://www.thestar.com/news/gta/2018/07/24/fate-of-ontario-safe-injection-and-overdose-prevention-sites-in-limbo.html.

[51] Ministry of Health and Long-Term Care. (2018, September 28). Statement by Deputy Premier and Minister of Health and Long-Term Care on overdose prevention sites and supervised consumption services. https://news.ontario.ca/mohltc/en/2018/09/statement-by-deputy-premier-and-minister-of-health-and-long-term-care-on-overdose-prevention-sites-a.html

[52] MOHLTC, (2018, October 22). Backgrounder: Review of supervised consumption services and overdose prevention sites--key finding.

[53] Registered Nurses' Association of Ontario. (2018, August 2). Open letter to Health Minister Christine Elliott: Save lives during the overdose emergency by implementing public health evidence. https://rnao.ca/sites/rnao-ca/files/RNAO_letter_to_MOHLTC_re_OPS_and_SIS_August_2_2018.pdf

[54] Potier, C., Laprévote, V., Dubois-Arber, F., Cottencin, O., & Rolland, B. (2014). Supervised injection services: What has been demonstrated? A systematic literature review. *Drug and Alcohol Dependence*. 145: 48-68.

[55] Kennedy, M., Karamouzian, M., & Kerr, T. (2017). Public health and public order outcomes associated with supervised drug consumption facilities: A systematic review. *Current HIV/AIDS Reports*.14(5): 161-183.

[56] MOHLTC, (2018, October 22). Media release: Ontario government connecting people with addictions to treatment and rehabilitation.

[57] Pilieci, V. (2018, October 22). Ottawa's safe-injection sites need to re-apply for provincial funding. *Ottawa Citizen*. https://ottawacitizen.com/news/local-news/ottawas-safe-injection-sites-need-to-re-apply-for-provincial-funding

[58] Cheevers, M. (2018, October 22). Pause lifted on St. Catharines overdose-prevention site. *Niagara This Week*. https://www.niagarathisweek.com/news-story/8980895-pause-lifted-on-st-catharines-overdose-prevention-site/

[59] Middlesex-London Health Unit (2018, November 1). Temporary OD prevention site to operate through end of 2018 as proposed permanent sites receive federal approval.

[60] RNAO, (2018, October 22). Media release: Province's support of supervised injection services and overdose prevention services welcomed by RNAO.

[61] Ontario Ministry of Environment, Conservation and Parks. (2018). *A Made-in-Ontario Environment Plan.* Nov. 29. https://prod-environmental-registry.s3.amazonaws.com/2018-11/EnvironmentPlan.pdf.

[62] Winfield, M. (2018). *The Ontario Climate Change Plan: An Assessment.* December 3. http://marksw.blog.yorku.ca/2018/12/03/the-ontario-climate-change-plan-an-assessment/.

[63] Under the *Climate Change Mitigation and Low-carbon Economy Act, 2016,* which was repealed by Bill 4. https://www.ontario.ca/laws/statute/16c07/v4.

[64] Legislative Assembly of Ontario. (2018). *Bill 4, Cap and Trade Cancellation Act, 2018.* July 25. https://www.ola.org/en/legislative-business/bills/parliament-42/session-1/bill-4.

[65] Ferguson, R. (2018). Doug Ford promises to cut gas prices by 10 cents a litre. *Toronto Star.* May 16. https://www.thestar.com/news/queenspark/2018/05/16/doug-ford-promises-to-cut-gas-prices-by-10-cents-a-litre.html

[66] Legislative Assembly of Ontario. (2018). *Bill 34, Green Energy Repeal Act, 2018.* Sept. 20. https://www.ola.org/en/legislative-business/bills/parliament-42/session-1/bill-34/status.

[67] Registered Nurses' Association of Ontario. (2018). *RNAO Submission on Bill 34, the Green Energy Repeal Act: Speaking Notes.* https://rnao.ca/sites/rnao-ca/files/RNAO_Speaking_Notes_Bill_34_Final.pdf.

[68] Ontario. (2018). *Ontario to Cancel Energy Contracts to Bring Hydro Bills Down.* July 13. https://news.ontario.ca/mndmf/en/2018/07/ontario-to-cancel-energy-contracts-to-bring-hydro-bills-down.html.

[69] Legislative Assembly of Ontario. (2018). *Bill 66, Restoring Ontario's Competitiveness Act, 2018.* https://www.ola.org/en/legislative-business/bills/parliament-42/session-1/bill-66.

[70] Canadian Environmental Law Association. (2018). *Deregulation Redux: Ontario's Environmental Laws under Attack (Again).* http://www.cela.ca/blog/2018-12-07/deregulation-redux-Ont-envl-laws-under-attack-again.

[71] Metrolinx. (2008). Costs of road congestion in the Greater Toronto and Hamilton Area: Impact and cost-benefit analysis of the Metrolinx Draft Regional Transportation Plan. http://www.metrolinx.com/en/regionalplanning/costsofcongestion/ISP_08-015_Cost_of_Congestion_report_1128081.pdf.

[72] Transport Action Ontario. (2018). *Comments on your Public Transportation Platform for Ontario.*July 3). http://ontario.transportaction.ca/wp-content/uploads/2018/07/TAO-LettertoFord-2018-07-03.pdf.

[73] Mackenzie, H. (2018). *Doing the math on the PC platform.* June 5. http://behindthenumbers.ca/2018/06/05/doing-the-math-on-the-pc-platform/.

[74] World Atlas. (2018). *Canadian Provinces and Territories by Per Capita GDP.* https://www.worldatlas.com/articles/canadian-provinces-and-territories-by-per-capita-gdp.html.

[75] RBC. (2018). *Canadian Federal and Provincial Fiscal Tables: Program expenses per capita.* September 27. P. 10. http://www.rbc.com/economics/economic-reports/pdf/canadian-fiscal/prov_fiscal.pdf. Figures for 2016-17 and projected for 2017-18. Copyright by owner. All rights reserved.

[76] RBC. (2018). *Canadian Federal and Provincial Fiscal Tables: Program expenses relative to GDP.* September 27. P. 11. http://www.rbc.com/economics/economic-reports/pdf/canadian-fiscal/prov_fiscal.pdf. Copyright by owner. All rights reserved.

Registered Nurses' Association of Ontario

158 Pearl Street
Toronto, Ontario M5H 1L3
416-599-1925
1-800-268-7199

Ontario Pre-Budget Submission 2019

RNAO.ca