Ontario Long Term Care Association Pre-Budget Submission to the Ontario Government 2015/2016

January 2015

BUILDING resident-centered long-term care, now and for THE FUTURE.
62% of residents live with Alzheimer’s disease or other dementias; nearly one third have severe cognitive impairment. People with Alzheimer’s and other dementias have always been part of the long-term care population, but since 2008, the proportion of residents with dementia has increased by 6%, and mild or moderate cognitive impairment has risen by 8%.

46% of residents exhibit some level of aggressive behaviour, and the incidence has been increasing. Between 2010 and 2012 alone, there was a 14% increase in moderately aggressive behaviour.

1 in 2 residents has a psychiatric diagnosis such as anxiety, depression, bipolar disorder, or schizophrenia. Dual diagnosis, such as dementia coupled with a psychiatric diagnosis, is increasing at 11% per year.

93% of residents have two or more chronic diseases, with notable increases in the proportion of residents with common conditions such as arthritis and heart disease.

22% – 24% increase in the number of residents who need help with activities of daily living such as toileting (22% increase), personal hygiene (23% increase), and dressing (24% increase).

Source: Excerpted from This is Long-Term Care 2014 by the Ontario Long Term Care Association, available at www.oltca.com. Data references are available in the report.
THE RIGHT CARE FOR OUR SENIORS, RIGHT NOW.

In the past five years, the long-term care sector has undergone profound change. Before then, LTC Homes accommodated a mix of residents with low to very high care needs. Since 2010 however, only people with high or very high care needs are eligible for long-term care in Ontario. The result: Ontario seniors are entering LTC Homes when they are older, frailer, and in need of more medical and personal care than ever before.

These changes are largely due to the province’s aging-in-place strategy, which has made more funding available for care at home while implementing new, stricter admission criteria for those entering long-term care. The more complex health needs of these new residents are not just increasing the demands on LTC Homes, they are effectively and demonstrably changing the role of long-term care in Ontario’s health care continuum.

Our LTC Homes have reached a critical time in this evolution of care. Provincial funding has not kept pace with the changing demographic of the seniors staying in LTC Homes. If we do not modernize the way our homes are funded, our seniors will start to feel the negative consequences of fewer staff, and dwindling resources. Solutions are needed not only to sustain current care, but also to improve the services being provided.

As Canada’s largest long-term care association, we are working hard to support the government’s direction and to ensure it is successful in securing the sustainability and quality of the care we are providing to almost 70,000 seniors annually. To do that we have been advocating for increased funding, revised regulations, and expanded specialty programs such as Behavioural Supports Ontario. Now, more than ever, residents need government to act on these recommendations, and support LTC Homes in their continued efforts to ensure residents receive the safe, quality care they need, both now and in the future.

Better care, better value

For some long-term care residents, the future is already here, with homes safely delivering new procedures like peritoneal dialysis, IV therapy, and tracheotomy care. Enabling LTC Homes to provide even more complex care is an idea whose time has come, not only because LTC Homes can, but because residents and their families need them to. And the constraints of the provincial budget require that we do things differently.

A recently released study comparing the cost of delivering care to clinically similar patients found that long-term care could do the job at a fraction of the cost of inpatient and complex continuing care environments (see Table 1). Clearly LTC Homes can provide better quality of life to residents and better value to taxpayers simultaneously.

<table>
<thead>
<tr>
<th>Hospital/ Mental Health</th>
<th>Other Health Sectors Per Diem Cost</th>
<th>Long-Term Care Per Diem Cost</th>
<th>Cost Difference (Savings) Per Resident Per Day</th>
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</thead>
<tbody>
<tr>
<td>ALC Beds</td>
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<tr>
<td>CC Beds</td>
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<tr>
<td>MH Beds</td>
<td>$692</td>
<td>$145</td>
<td>$547</td>
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</table>

Source: Preyra Solutions Group, 15 Ways to Improve Long-Term Care Funding
The need to enable creative solutions

Creative and innovative solutions are desperately needed within long-term care and across the entire health care system itself. LTC Homes are struggling with the dire reality that they are funded for a less complex population that they no longer serve, while their desire to find solutions is impeded by the most onerous set of regulations governing any health care provider in Ontario.

Ontario’s seniors deserve better care now. They need LTC Homes that are ready and capable of meeting their ever-increasing, complex health care needs and able to provide safe quality care when they expect and require it most. We have a simple plan that, with your support, can make a real difference to those needing long-term care, both now and in the future. Our plan consists of five key enablers:

1. Matching staff resources to the demand for care
2. Supporting mental health and dementia care
3. Meeting rising operational costs
4. Tending to our aging LTC Home infrastructure
5. Supporting smaller LTC Homes

IN PERSPECTIVE: WHAT DOES A LONG-TERM CARE HOME DO AND HOW DOES IT WORK WITH THE HEALTH CARE SYSTEM?

Long-term care homes, and the process through which people are admitted, are rarely on people’s minds until they need long-term care for a family member. As a result, there is little public understanding of how the process works.

In Ontario, Community Care Access Centres (CCACs) are the gatekeepers of long-term care. A family doctor, hospital, family member, or home care worker may tell the CCAC that it is no longer possible to keep the person in his or her home, but the CCAC conducts the assessment and makes the decision.

Long-term care homes report that new families are often unsure about the purpose of long-term care, and often confuse them with retirement homes. Long-term care homes are partially funded by the government to provide primary health care and nursing care; rehabilitation, physiotherapy, and other restorative therapies; recreational activities; help with the activities of daily living; and special diets.

They also provide a caring community, focused on helping residents live comfortably and with dignity in a safe environment at the end of their lives. Long-term care homes are run by privately owned and publicly owned companies, non-profit/charitable organizations, and municipalities. These organizations own the buildings and are granted term licences and funding by the government to operate long-term care homes.

From the government’s perspective, long-term care provides more support and services than can be provided through home care, and less expensively than in hospital.
1. Matching staff resources to the demand for care

WHAT IS NEEDED:

- Increase funding for both nursing and personal care (NPC), and program and support services (PSS) by 2.85%.
- Relax the restrictive 24/7 registered nurse (RN) requirements and recognize the ability of personal support workers (PSWs) and registered practical nurses (RPNs) to work to their full scope of practice.

With the infusion of Nurse Practitioners (NPs) and Physician Assistants (PAs) into the sector and the challenge of recruiting RNs in some areas of the province, allowing for a flexible 24/7 nursing requirement based on individual LTC Home needs is a more effective use of health care dollars and allows staff to deliver more hands-on care to our frail population of seniors.

HOW AN INCREASE IN STAFF FUNDING WILL HELP:

Research demonstrates that the complex needs of today’s long-term care seniors are higher than homes were originally intended to provide and they will continue to rise in the future. Simply put, more resources are needed. Within Canada, the daily funding provided in Ontario for long-term care is the lowest among reporting provinces.

As the care needs of today’s new long-term care residents increase, so does the staff’s workload. These increased care needs are measured by an acuity scale the Ministry of Health and Long-Term Care has used for the past five years, namely, the Resident Assessment Instrument – Minimum Data Set. This measure of acuity is used by the MOHLTC to adjust funding – not in absolute terms but by dividing the existing NPC funding, so if a home has a higher acuity measure it gets a larger share of the funding than a home with a lower acuity measure.

By applying this measure of acuity to the existing population of Ontario residents living in long-term care, we know that these homes will require a 1.1% overall increase in NPC funding (an overall increase for the 12-month period ending March 31, 2013 to the 12 months ending March 31, 2014). This is necessary just to ensure that staffing levels are sufficient to meet the care requirements of the residents currently in homes.

In addition to the increase required because of the greater care needs of the residents, there’s also a regular increase of 1.75% required to cover the cost of maintaining current staff.

This 1.75% is based on two factors. First is the observation that almost all 2014 labour contracts in LTC Homes that went to arbitration for settlement saw increases of 1.5% in hourly wage rates. The second is the cost of benefits. Without taking into consideration any future improvements to these benefits, they are costing homes at least 2.5% more. The resulting total increase in costs to maintain current staffing is 1.75%. The NPC funding is used almost entirely to fund staff wages (95%), with the balance going to nursing supplies and equipment.

Frontline care staff in long-term care

<table>
<thead>
<tr>
<th>Role</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurses</td>
<td>9.5%</td>
</tr>
<tr>
<td>Registered practical nurses</td>
<td>18.4%</td>
</tr>
<tr>
<td>Personal support workers</td>
<td>72.1%</td>
</tr>
</tbody>
</table>

Source: LTCH Staffing Data, Ministry Funded Portion, 2013
Therefore, an increase of 2.85% is required to maintain existing staffing levels and to ensure that we can support the increasing costs of providing our seniors with the care they need, based on their documented changes in acuity. Anything less than 2.85% will mean a significant reduction in our ability to provide seniors with appropriate levels of care.

Table 2: Paid hours per resident day

<table>
<thead>
<tr>
<th>Paid Hours Per Resident Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
</tr>
<tr>
<td>RPN</td>
</tr>
<tr>
<td>PSW</td>
</tr>
</tbody>
</table>

Source: Long-Term Care Homes Staffing Report, Ministry Funded Portion, 2013

Program and support services must also be considered

The same rationale extends to the need for a 2.85% increase to the program and support services (PSS) functions. PSS funding is used to provide a wide range of recreational and care activities such as physiotherapy and the services of a dietician to develop individual dietary menus for residents.

Of the total PSS funding, an estimated 92% is used for salaries, benefits and contract services. As it does with NPC functions, the need for greater PSS staff resources comes from the increased care requirements of residents. For example, residents with higher acuity require greater individual and small group activities. And the inflationary pressures on PSS staff costs are the same as with NPC.
Research demonstrates increased acuity

Although Ontarians are living longer due to advances in medicine and technology, they are also living with multiple chronic conditions that require specialized care coordination and support. According to the Ontario Association of Community Care Access Centres (OACCAC), in 2012, 85% of new admissions to long-term care from the community, and 78% from hospitals, had high or very high scores of 4 or 5 indicating the highest care needs possible, according to the Method for Assigning Priority Levels (MAPLe). Less than 1% of new long-term care admissions were low needs clients with MAPLe scores of 1 or 2.

The latest CIHI data shows that Ontario’s long-term care residents have prevalence rates of endocrine, metabolic, pulmonary and heart/circulatory diseases similar to patients in complex continuing care hospitals – and much higher than residents in other provinces. As the information in Chart 3 shows, these and other medical conditions continue to increase. At the same time, residents’ need for assistance with activities of daily living continues to increase (see Chart 4).

Chart 3: Increase in chronic conditions over 5 years

![Chart 2: Program and support services cost breakdown](source: 315 Long-Term Care Home Annual Reports, 2012)
Chart 4: Increase in the need for support of daily living activities over 5 years

These residents require more personal support worker time, yet according to the latest Ministry staffing data, the ratio of PSW full time equivalents has remained relatively constant at 2.2 hours per resident per day. Clearly this situation is unsustainable and puts the safety of both residents and staff at risk.

**Solution:** Increase funding for both nursing and personal care and program and support services by 2.85%.

**Rationale:** The increasing acuity and medical complexity of LTC residents requires an immediate increase in NPC and PSS funding of 2.85%. This would provide for the increasing costs of existing staff and allow homes to add staff necessary to look after the greater care needs of today’s residents and assist in an environment where there are enhanced performance requirements, strengthened infection prevention and control measures, and a reduction in emergency room transfers.

**HOW STAFF WORKING AT FULL SCOPE OF PRACTICE CAN HELP:**

One of the most efficient ways to increase access to safe, high quality care for residents is to allow health care practitioners in the sector to work to their full authorized scope of practice. For no additional cost, this change would increase the capacity of LTC Homes to meet the growing medical complexity of care.

Currently, LTC Homes are operating with reduced care teams and depend on nurses to perform tasks that can be easily and safely delegated to PSWs. As The Long Term Care Homes Act, 2007 (LTCHA) does not allow certain tasks to be delegated, staff and nurses struggle to deliver individualized resident care. This situation also perpetuates the reliance on standardized care routines and creates a busy, rushed, ‘institutional’ environment focused on completing tasks. And it limits RN and the RPN’s ability to supervise and mentor PSWs and make the required shift from a custodial to resident-centred model of care.
The Regulated Health Professions Act, 1991 (RHPA) defines 14 controlled acts that no person can perform while providing health care services unless they are authorized to perform the controlled act(s) by their professional legislation, or they are delegated to perform these acts by a person authorized to perform them. The Long-Term Care Homes Act is unique in that it does not allow RNs and RPNs to delegate these 14 controlled acts. No such limitation exists elsewhere in health care or even in retirement homes.

IN PERSPECTIVE: HOW THE ACT LIMITS MEDICATION ADMINISTRATION

In the community sector, PSWs regularly administer medications as part of their expected role in the home care services delivered to some 200,000 CCAC clients on a daily basis. Following their unsupervised visit in the client’s home, PSWs are required to report to a supervisor any observed changes in the client, including adverse events. Ontario’s new legislation governing retirement homes includes provisions that echo the requirements under RHPA for authorization and delegation of medication administration to unregulated staff.

By contrast, the Long-Term Care Homes Act O. Reg. 79/10 Section 131 restricts the administration of a drug to a doctor, registered nurse, registered practical nurse, and a dentist. Recent amendments to O. Reg. 79/10 enable student nurses to administer medication but have not addressed the authorized scope of practice or delegation authority related to medication administration for pharmacists, medical students and physician assistants. For example, even though pharmacists have started to administer flu shots in the community, it would require an amendment to the Regulation for them to administer annual flu shots to residents of LTC Homes, who are among the highest priority for immunization.

OLTCA recommends that health care providers in long-term care be supported to work to full scope of practice by amending the Act and its Regulation so that where the provisions of the Act and its Regulation are inconsistent with the provisions of the Regulated Health Professions Act, 1991 (RHPA), the provisions of the RHPA prevail. We also recommend changing the 24/7 RN Regulation to a 24/7 Nursing Regulation, which will allow individual homes to staff to the appropriate care needs and maximize the amount of direct, hands-on care, while maintaining professional safety and quality in the homes with a full care team consisting of a continuum of care providers such as physicians, NPs, RNs, RPNs, PAs and PSWs.

Solution: Allow all care staff to work to full scope of practice in long-term care.

Rationale: RNs and RPNs have the identical scope of practice and similar authority to perform/initiate controlled acts. Alignment with the RHPA and the Nursing Act would enable LTC Homes to better deploy clinical expertise and all resources available to meet the increasingly complex medical needs of residents at no additional cost to the system.
2. Supporting mental health and dementia care

WHAT IS NEEDED:

• Up to an additional $60 million to build on the growing success of Behavioural Supports Ontario.

This program has been very helpful in dealing with behaviours when homes have access to these as in-house resources. The latest information shows that 109 LTC Homes received direct funding to provide staff resources specifically trained in dealing with behaviours. Other homes received funding indirectly to deal with resident behavioural issues but are provided very limited resources.

OLTCA would like to see the current estimated $15 million used for in-home programs to grow to $75 million over the next three years. This is based on calculations that see funding provided at $2.75 per resident per day, which allows for 0.5 FTE RPN and 0.5 FTE PSW for every 64 beds.

HOW GROWING THE BSO PROGRAM WILL HELP:

Currently, 46% of long-term care residents have some level of aggressive behaviour, and one in three has a psychiatric diagnosis. Residents with aggressive behaviours are a core component of the population in long-term care. More dedicated and specialized resources are needed to build capacity and provide care for their needs, while maintaining the safety of homes for all.

The prevalence of dementia and chronic mental health conditions in the elder population has increased noticeably in the past decade. The same is true of neurological and behavioural disorders among LTC residents.

Also, as a result of the closing of mental health beds province-wide, homes in some local health integration networks (LHINs) are reporting dramatic changes in the profile of newly admitted residents with mental health conditions.

According to an analysis of the Continuing Care Reporting System (CCRS) conducted by Dr. Jeff Poss between 2008 and 2013:

• The proportion of residents with cognitive impairment rose by 7.7%;
• Residents with dementia rose by 5%;
• Residents with psychiatric/mood disorders rose by 5.7%, and;
• Residents with aggressive behaviours rose by 7.4%.

Source: 15 Ways to Improve Ontario’s Long-Term Care Funding Model.
Almost all of Ontario’s LTC Homes have serious behavioural incidents

As for the growing mental health profile, an OLTCA survey of 440 member homes conducted in November 2012 found that nearly all (91%) of responding homes experienced one or more critical incidents serious enough to require external reporting. Half had reported five or more serious incidents related to responsive behaviours in the previous six months.

Nearly two-thirds (65%) of homes had to call the police at least once during that same time period due to a resident’s violent behaviour – this percentage is up from 49% in 2007. Over half (55%) of responding homes reported having to forcibly transfer a resident to a psychiatric facility or emergency department for assessment during the same period. More alarmingly, in 90% of these cases, the resident was returned to the home without an adequate assessment, new medication or physician orders, or a revised care plan.

Homes are concerned about the ability of their staff to safely care for these residents without a dedicated in-house team to prioritize these specific care needs. The safety of residents and staff must become a priority for Ontario. In the initial approximately $60 million dollar BSO investment, some LHINs have adopted a BSO Outreach model that LTC Homes are finding not as effective when addressing their resident needs. LTC Homes are waiting anywhere from days to weeks for assistance under this model of care, which is reactive and does not support residents’ quality of living in real-time as required. There are instances where aggressive or violent triggers are resulting in transfers that could have been avoided by having in-home expertise working to decrease the incidence of aggressive triggers.

IN PERSPECTIVE: The problem with mobile BSO teams

The following feedback was provided by an administrator of a rural LTC Home that currently relies on mobile BSO teams not based in the home:

“We have one resident with psychiatric issues who is at very high risk for aggression towards other residents. Staff and our Residents’ Council have deep concerns about safety, and after a hospitalization, we accepted him back into the home only on condition that he would have BSO support days and evenings. The regional BSO teams have been unable to provide this staffing on a regular, consistent basis.

The mobile team only gets a snapshot of a resident’s behaviour because they are not here on a regular basis. But continuity of staffing is very important to gain knowledge of a resident’s triggers and interventions that work. Because the BSO staff are not part of the home, they don’t know our residents as well as staff do. They also aren’t familiar with our organization’s values, policies, or procedures and use a different charting system, which creates double the work as our staff then need to re-enter the information in our own system.”

Other observations concerning mobile BSO teams:

- “They don’t provide one-on-one care; they function as an observer and consultant to the home, and sometimes their recommendations exceed what’s possible for us to do within our staffing capacity and environment.”
- “Response times vary. Sometimes they have no staff available to assist us. If a more pressing issue in another LTC Home comes up they will ‘prioritize the risk’ and pull their scheduled staff from our home – but our residents still need that support too.”
**Solution:** The mobile BSO team model is not working. It’s time for government to make the investments necessary to have an in-home BSO team in every home in the province. Re-allocation of the funds being used for the mobile model will help mitigate some of the additional costs to do this. We estimate the cost to be about $75 million once fully implemented over a three-year period.

**Rationale:** The original investment for in-home BSO did not all go into LTC Homes. Some LHINs directed those dollars to programs that only provide the service occasionally to some homes, through a mobile BSO team. This model does not provide the hands-on, readily available access that our seniors who suffer from mental health and dementia need. By increasing the current investment from $15 million to $75 million, capacity would be established to address the needs of residents with aggressive behaviours in every LTC Homes in Ontario. It would also allow the homes to support a Psychotropic Stewardship program where dedicated staff could prepare individualized approaches to in-home medication and behavioural mapping and assessment tools.

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**IN PERSPECTIVE: The benefits of an in-home BSO team**

The following feedback was provided by David Towers, the executive director of Riverside Place, a Revera home in Windsor that has seen dramatic results using an in-home BSO team:

“One new resident was very combative soon after admission. He regularly screamed and yelled, telling the staff, “I’m going to shoot you!” The staff went to our BSO team for help. The BSO team monitored him and how staff interacted with him. The team interviewed his family members as well, trying to figure out any triggers and personal history. The team concluded a lot of his behaviour had to do to a loss of control. He still saw himself as a 21-year-old man with full control of his body – and who were these people to boss him around? So staff learned to make suggestions, rather than give him directions. They learned what to say, why to say it, and how to say it – and the aggression disappeared.”

**Towers provided further background:**

In 2010, there were 22 serious resident-to-staff assaults including punching, kicking, scratching, and biting. In 2011, there were 18 of these assaults. In an effort to reduce these serious incidents, Riverside Place first moved residents with Alzheimer’s and dementia-related issues to one 32-bed unit and then ensured they had consistent staffing in that unit. The home also participated in Health Quality Ontario’s Residents First project. Despite these efforts, Riverside Place continued to experience assaults and a median of 145 incidents of physical aggression a month towards staff.

Within four months of implementing a BSO team in February 2013, the home saw a 40% drop in physically aggressive behaviour on the unit. As of December 2014, there has been a sustained 75% reduction in physical aggression. And the assaults have been almost entirely eliminated.

Riverside Place has solid evidence to show the benefits of an in-home BSO team because of their prior participation in Residents First. They were given specific indicators to track, which clearly demonstrate the progress that has been made since the BSO team was put in place (See Chart 6).

*continued*
Riverside Place has a part-time BSO team of one RPN and two PSWs, who work the rest of the time as full-time staff on the unit where residents with behavioural challenges are concentrated. For the first three months, the team worked full-time exclusively in a behaviour support role, learning all they could about every resident – interviewing staff and families, discussing potential triggers and potential interventions, and testing the interventions while observing the resident. The BSO team then developed responsive behavior care plans and provided individualized instructions for each resident. The same process continues to be followed for every new resident.

While the home uses the region’s mobile BSO team as a resource, Towers said an in-home team is important because members know the residents and staff. “The team not only helps to reduce residents’ challenging behaviour, they teach, build relationships, and help change the culture to a more resident-focused approach – something that’s a lot harder to do when you’re outside an organization,” he said.

**Chart 6: Reduction in aggressive behaviours on Pelee Unit in Riverside Place using in-house BSO team.**

The team was introduced in February 2013 and developed behavioural management care plans for each resident by May 2013.
3. Meeting rising operational costs

WHAT IS NEEDED:

- Increase resident co-payment by the greater of 0.5% over the Consumer Price Index (CPI), or 2.75%.
- Allow LTC Homes to retain 100% of the resident co-payment increases just as hospitals are permitted to do for their complex continuing care beds.

HOW INCREASING CO-PAYMENT WILL HELP:

The government does not pay the full cost of long-term care and requires residents to pay most of their ‘room and board’ expense to the LTC Home. The government sets the amount residents must pay the LTC Home, with an opportunity for the resident to qualify for a subsidy based on their level of income. For example, someone paying a basic accommodation rate (currently $56.93 per day) without a subsidy would pay $1,732 per month.

Since 2012, the government has been increasing resident co-payments annually by CPI plus 0.5%. Actual co-payment rates vary by province, but those in Ontario are among the lowest in Canada.

While resident co-payment has been increasing at a rate that is 0.5% greater than CPI, the amount of the increase that is effectively retained by LTC Homes has been decreasing. Whereas LTC Homes have only been receiving 48% to 63% of the increase in the resident co-payment, hospitals have been receiving 100% of the increases for their complex continuing care beds.

<table>
<thead>
<tr>
<th>Province</th>
<th>2013 Co-Payment* per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>NB</td>
<td>$107.00</td>
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<tr>
<td>NS</td>
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<td>BC</td>
<td>$100.57</td>
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<td>NFL</td>
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<td>SK</td>
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<td>ON</td>
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<td>AB</td>
<td>$48.15</td>
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<td>QB</td>
<td>$36.10</td>
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</tbody>
</table>

* Before Rate Reduction or Equivalent

HOW INCREASING ‘OTHER ACCOMMODATION’ FUNDING WILL HELP:

Other Accommodation (OA) funding is used to pay for a wide range of expenses. It is primarily funded through resident co-payments with some additional funding through the province. Chart 7 (on next page) provides a breakdown of the main uses of this funding based on a sample of approximately 50% of the annual audited financial reports of LTC Homes filed with the Province in 2012. These expenses include all salary, supply and equipment expenses for the dietary, housekeeping, laundry, maintenance and general and administrative departments.
The OA envelope is also used to pay for utilities, a portion of property taxes, insurance, maintenance contracts, repairs to the building and its operating systems, and professional fees including labour negotiations and arbitration costs. Notably, over half of the OA funding goes directly to salaries, benefits and wage-related costs. However, as these homes continue to age, there is an ever-increasing need for capital repairs and the escalating cost pressures that flow from them.

Additionally, all administrative expenses are covered by the OA funding including office supplies, communication (phones and internet), accounting, recruitment, payroll and other human resources expenses for all staff and departments, including nursing and personal care. As well, the government only reimburses the home for 50% of their bad debt costs (e.g. uncollected resident co-payment amounts) even though homes have few tools and limited means to enforce or collect amounts from residents that refuse to pay.

The challenge is that 84% of OA income is spent on other accommodation expenses. The risk is that this leaves just 16% available for items such as roof and heating system repairs, furniture, hospital beds (including special high-low and geriatric beds) and technology infrastructure (e.g. wiring and connectivity for point of care). This 16% must also cover excess costs (beyond what is funded) for nursing and personal care, program and support services and ‘raw food’ envelopes; interest and principal debt payments; and corporate income tax (where applicable).
Recent increases in Other Accommodation funding have been lower than inflation

Currently the Province provides $52.76 for Other Accommodation. Since 2010, the increase in the OA funding has been limited to between 74% and 81% of CPI. The reality is that majority of OA expenses experience cost pressures in excess of CPI (e.g. salaries, benefits, utilities, etc.). This of course brings into question the appropriateness of using CPI as a legitimate proxy for determining increases in OA funding, let alone providing increases that are only a fraction of CPI.

Table 4: Increasing Other Accommodation Expense

<table>
<thead>
<tr>
<th>OA Expense</th>
<th>% of Total OA Expense</th>
<th>% Increase 2012 to 2013</th>
<th>% Increase 2010 to 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries, Benefits and Purchase Services</td>
<td>45.3</td>
<td>1.9</td>
<td>9.5</td>
</tr>
<tr>
<td>Utilities</td>
<td>7.6</td>
<td>3.0</td>
<td>3.7</td>
</tr>
<tr>
<td>Property Tax</td>
<td>1.5</td>
<td>-2.3</td>
<td>-4.6</td>
</tr>
<tr>
<td>Insurance and Communications</td>
<td>1.1</td>
<td>15.0</td>
<td>35.3</td>
</tr>
<tr>
<td>Supplies and Equipment</td>
<td>5.4</td>
<td>3.4</td>
<td>9.3</td>
</tr>
<tr>
<td>Maintenance and Building Services</td>
<td>3.6</td>
<td>4.7</td>
<td>22.0</td>
</tr>
<tr>
<td><strong>Total Increase</strong></td>
<td></td>
<td><strong>2.5</strong></td>
<td><strong>9.4</strong></td>
</tr>
<tr>
<td><strong>CPI</strong></td>
<td></td>
<td><strong>0.9</strong></td>
<td><strong>5.4</strong></td>
</tr>
</tbody>
</table>

*Source: Sample of 164 LTCH Annual Reports, 2010-2013

Solution: It is recommended that co-payments increase by the greater of CPI + 0.5% or 2.75% and that Other Accommodation funding (aspects of operating an LTC Home that do not include resident care) also see the same percentage increase.

Rationale: Other Accommodation funding that is arbitrary in nature, and that fails to appropriately recognize the cost pressures impacting the expenses related to it, creates undue risk for the sector and the residents for which it provides both care and accommodation. Since 2010, the increase in OA funding has been limited to between 74% and 81% of the national annual Consumer Price Index increase, while the majority of OA costs, like salaries and utilities, are subject to inflationary increases, which tend to increase at or above the annual CPI rate.

At the same time the government is charging residents more for their accommodation through increases to resident co-payments that exceed CPI by 0.5%. The inconsistency and incongruity of this approach to funding and charging for resident meals and accommodation seems inexplicable. To address this and to ensure the appropriateness of future funding, OLTCA also recommends that both resident co-payments and the corresponding funding be increased at a rate that reflects the real cost pressures for OA expenses and ensures sufficient funds are available for capital repairs and maintenance.
4. **Tending to our aging LTC Home infrastructure**

**WHAT IS NEEDED:**

- **Ongoing commitment to build on the recently announced Enhanced Long-Term Care Home Renewal Strategy.**

**HOW THE SUCCESS OF THE ENHANCED LTC HOME RENEWAL STRATEGY WILL HELP:**

In October 2014, the Ontario government announced a renewed capital redevelopment plan for LTC Homes. This has been well-received by LTC Home operators who are keen to bring their homes up to the current standards. Indeed, some 52% of Ontario’s older LTC Homes – many of them in small communities or rural locations – currently do not meet the most recent (2009) design standards. For example, older homes have three or four-bed wards and cramped living spaces, which do not meet the needs of residents living with dementia and Alzheimer’s.

Having individual rooms and basic rooms with only two residents, as well as ‘home-like’ amenities, can help to create a safe and secure living environment for both residents and staff while respecting residents’ privacy and dignity. The new standards also help with infection control and preventing outbreaks. In addition, older homes may not be fully equipped with fire sprinkler systems and other important life safety mechanisms that are needed to provide safe and supportive care.

The enhanced capital redevelopment plan for long-term care announced by the Province is a promising start. OLTC is committed to working with the government to determine the appropriate levels of public-private investment that will make the program successful and that ensures existing operating models and policies support those investments.

**Need for funding that supports a viable sector**

If the Province continues the practice of restricting the OA increases to a percentage of CPI, in 25 years (current term of the capital funding being provided by the Province), LTC Homes will be receiving between $8.00 and $10.00 (in 2014 dollars) less in funding per resident per day than at present, assuming a 2.0% per annum increase in CPI. Operators require long-term, appropriate funding to meet the minimum debt service requirements of their lenders. OLTC also recommends that the government put a policy in place that provides for fair and consistent increases to the OA envelope. OLTC also recommends that the percentage increase in the OA be equal to the increase in the resident co-payment.

**Solution:** OLTC was pleased to hear the Province announce an Enhanced Long-Term Care Home Renewal Strategy that includes additional funding and the ability to obtain design variances. We are looking forward to working out the details through a consultative approach that allows for information sharing and strategizing for the best possible outcomes. For the program to be successful, it is essential to provide annual increases in OA funding that fairly reflect these increasing costs. Additionally we must work collaboratively to address: capacity planning, licensing issues (includes new beds and the movement of beds), and the real impediments to retaining and developing small and rural LTC beds, and those in dense urban centres such as downtown Toronto.

**Rationale:** Rebuilding Ontario’s older LTC Homes will improve resident safety, quality of life and quality of care. It is crucial to deliver a program that leverages the strength of the private, not-for-profit and municipal sectors as partners in capital investment. Together we must address capacity planning to identify where LTC beds are needed; explore how homes can be hubs for community care across the province; and provide a reasonably predictable funding increase in OA. These and other creative solutions will be needed to ensure these older LTC Homes will be ready and able to meet the needs of Ontarians before their licenses expire in June of 2025.
5. | Assisting smaller LTC Homes

WHAT IS NEEDED:

- Small homes need additional nursing and personal care funding so they can provide similar level of care staffing per resident as larger LTC Homes.

An additional $30,000 per small home plus $1.50 per resident per day would allow small LTC Homes to have similar staffing levels as medium-sized LTC Homes. This would amount to an $8 million investment that would provide for an estimated 150 FTE positions.

HOW THIS INVESTMENT IN SMALL HOMES WILL HELP:

There are 139 LTC Homes with 64 beds or less in Ontario. And many of these are located in small communities or rural areas without any other LTC Homes close by. These small homes not only provide for the care needs of seniors in their communities, they are also major employers. They play an important role in the health care continuum, but need real solutions and a clear strategy if they are going to continue.

LTC Homes have had to implement a number of changes over the past five years while the care needs of their residents have grown significantly. More changes are coming, from how funding is provided to the implementation of quality improvement plans. Managing these change requirements while caring for increasingly frail and ill residents with multiple complex conditions is pushing the abilities of our LTC Homes to the limit, and potentially and unduly puts their residents at risk.

Small homes need additional care staff to meet changing roles and needs of residents

Small homes have very limited care administration resources and fewer direct care resources than larger LTC homes to meet growing demands. Based on staffing data collected by the Province, the current NPC funding provided to LTC Homes with 64 beds or less means they have 4.4% fewer direct-care hours per resident than a medium-sized home (65 to 128 beds) and 8.5% fewer hours per resident than large-sized homes (129 beds or more). For a 60-bed LTC Home, for example, this is the equivalent of needing one more full-time care worker if the small home had the same ratio of care staff as the medium home.

For small LTC Homes to continue delivering quality care in this increasingly more complex environment, they need more resources. Homes with 64 beds or less need funding to add nursing and personal care hours. Additional funding of $30,000 per small LTC Home, plus $1.50 per resident per day, would allow small LTC Homes to provide direct-care staffing equivalent to that of a medium-sized LTC Home.

In a 48-bed home, for example, this funding would provide for an additional full-time PSW. And in a 64-bed home, it would be the equivalent of having half a full-time RPN and half of a full-time PSW. These additional resources, which represent an additional investment of $8 million, would provide critical care resources the small LTC Homes require to continue to provide safe quality care.

The importance of long-term care in small, rural communities

The 139 LTC Homes with 64 or fewer beds represent 22% of all homes and 9% of the total beds in the province. Of these 139 homes, 58% are located in small or rural communities with a population of less than 10,000 people.

A key strength of long-term care in Ontario is its reach. LTC providers have a presence in 640 locations across Ontario. They provide a lifeline to family caregivers in distress, including those in rural, small and ethnic communities. They also employ thousands of Ontarians and are economic engines in areas where jobs, tax revenues and capital investment are hard to come by.
Susan is the director of care at a small home in rural Ontario. Due to the home’s small size and corresponding small operating budget, the home cannot afford a full-time director of care and Susan also serves as the home’s administrator.

It’s always been a busy job that requires her to wear multiple hats, but lately Susan has become very concerned about the home’s ability to provide a higher level of care to an increasingly frail and ill population. She knows her team needs more clinical leadership and mentoring than Susan can provide as a part-time senior RN. And as an administrator, she is struggling to keep up with the major health system changes in the last five years that have included new legislation and expectations around quality improvement, new funding arrangements and relationships with the LHINs, and government quality inspections that have increased in intensity.

Susan has applied for a nurse manager job that recently opened up at the regional hospital. She knows it will be difficult to recruit someone into her job at the LTC Home, but the part-time roles of director of care and administrator are no longer manageable and she doesn’t know what else to do.

**Administrative requirements are a growing burden for small homes**

Changes being implemented in the Ontario LTC sector have been numerous over the past five years, from the implementation of new responsibilities and regulations under the *Long-Term Care Homes Act*, to the introduction of LSAA requirements and indicators. Additionally there is the ever increasing reporting and documentation requirements from the LHINs, the MOHLTC (including indicators through Health Quality Ontario) and other government agencies such as the ESA, MOL, Fire Marshall’s Office, etc. The capacity of smaller homes to absorb this amount of change while maintaining safety and high quality of care for residents is limited by the scale of administrative resources at hand and the ever increasing administrative burden that our sector faces.

The risk of impact to resident safety and care of these pressures in smaller homes is concerning. While larger homes have more resources available to develop and deliver quality improvement initiatives, infection prevention and control programs, and to undertake necessary renovations, smaller homes often struggle to make these very necessary changes, in addition to addressing increasing reporting requirements.

OLTCA believes that a strategy to ensure consistently high performance across LTC Homes is essential to delivering on the government’s goal to provide the right care in the right place at the right time – in every community across Ontario.

**Solution:** Small homes need approximately $30,000 per home plus $1.50 per resident day in funding to bring direct-care staffing up to the level of a medium home. This would amount to an $8 million investment that would provide for an estimated 150 FTE positions.

**Rationale:** This will allow small homes to deliver the same level of care as a medium home and attract staff to these homes to assist in providing this care with more resources. It would also support the communities in which these small homes are such an integral part across the province.
Helping seniors live well and longer means investing in long-term care

The five priorities laid out in this document present a compelling picture of how working together, we can build the capacity of long-term care to better deliver on Ontario’s Health Action Plan. Ontario’s LTC providers know that helping seniors live well and longer means investing in long-term care. We believe that our priorities and recommendations for the 2015 Ontario Budget are not only what residents, families and our health care system need, but also what all Ontarians deserve.

Without appropriate, long-term funding, and some flexibility to introduce new solutions into our long-term care system, our homes are going to increasingly turn into institutions, not the caring homes that our seniors deserve. The funding challenges are real and need to be addressed. Right Now.

The Ontario Long Term Care Association and our members are committed partners in the delivery of safe, high quality and resident-centred long-term care now and for the future. We are proud of our history and track record as an efficient deliverer of quality health care and homes. We recognize that now more than ever, the government needs health care providers to work smarter and more efficiently. This budget proposal demonstrates our continued commitment to that goal; all we ask is for the tools to make it happen.

Most importantly, the recommendations laid out in this proposal demonstrate our strong commitment to our most important stakeholders – the 100,000 residents that live in Ontario’s LTC Homes annually, and their family and loved ones.

About the Ontario Long Term Care Association

Ontario Long Term Care Association (OLTCA) is Canada’s largest long-term care association and represents a full spectrum of charitable, not-for-profit, private and municipal long-term care operators. The Association’s 440 member homes are funded and regulated by the Ontario Ministry of Health and Long-Term Care and the province’s fourteen LHINs. OLTCA members provide health care and a home to almost 70,000 seniors annually.