



OANHSS

Submission to the Standing
Committee on Finance and
Economic Affairs:
Building a Seniors' Care
Continuum

January 2010

Ontario Association of Non-Profit Homes and Services for Seniors

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Introduction

The Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) is the provincial association that represents not-for-profit providers of long-term care (LTC), community services and housing for seniors. Our members include municipal and charitable long term care homes, non-profit nursing homes, seniors' housing projects and community service agencies. Collectively they operate over 27,000 LTC beds and over 5,000 seniors housing units.

LTC providers continue to face a dramatically increasing level of demand for beds and increasing levels of need in the population they serve. There are about 620 long term care homes with 76,359 beds province-wide. The overall demand for beds is increasingly outstripping supply. Waitlists are growing and there are virtually no beds available. The Ministry of Health and Long-Term Care (MOHLTC) places the current wait list count at 25,680, a 5.1% increase over last year. Vacancy rates continue to decline, in August of 2009, the average province-wide vacancy rate was approximately 0.4% (371 beds); down from last year's average rate of 0.7% (550 beds).¹ Beds are becoming scarcer.

¹ All figures from the Ministry of Health and Long-Term Care, Long-term Care Homes System Report, November 2009 and September 2008.

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Residents coming into LTC homes are older and sicker with more complex care needs than ever before. There are three areas of care where these pressures are greatest: assistance with Activities of Daily Living (ADLs), mental health and behaviours, and specialized medical needs.

Seventy-two percent of residents are at least 80 years of age or older, 94% require total assistance with dressing and 98% need at least some assistance with toileting. Almost all, 95%, require at least some assistance with eating. A similar proportion, 88%, requires at least one person to assist in transfers (e.g. assistance in moving from bed to wheelchair, etc.). A growing number of residents require special treatments such as chest drainage, feeding tubes and oxygen.

There is also an increasing number of residents suffering from mental health and/or behavioural issues that can put themselves or others at risk. One in three residents display aggressive/angry behaviour, 94% represent a potential risk, of varying degrees, for injury to themselves or others, and roughly 96% display ineffective coping ability that requires up to 30 minutes of intervention daily. These factors contribute to increased incidents of aggressive and violent behaviours from which homes are having great difficulty protecting residents and staff. Statistics from a group of five municipal homes will illustrate: in 2008 there were 250 acts of aggression, averaging roughly 1 per week per home – most of the aggressive acts were resident to resident.

In addition to referrals directly from the community, most residents are transferred to long-term care from hospitals, psychiatric facilities, and crisis situations in the community. This is a very high and specialized need population that the LTC system is not adequately resourced and equipped to provide for.

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Similar pressures are being experienced in community-based seniors care. Based on a 2009 OANHSS survey² of Assisted Living Services in Supportive Housing services (ALS-SH), commissioned by the MOHLTC, we know that over half of the province's ASL sites have waitlists and the remainder is operating at full or near full capacity. The duration of the average wait was reported to be anywhere from a month to 4 years. Province-wide, the average waitlist is 27 individuals long.

The population of seniors in the community is also experiencing increasing acuity. About two thirds of ALS-SH clients are over 80 years of age. Currently, virtually all ALS-SH referrals (96%) come from the local community and only 4% come from hospitals. Two out of five ALS-SH clients progress to long term care homes (LTCHs), 38% pass away while receiving ALS-SH services, and 12% move to hospitals or complex continuing care. One half of those that are transferred to LTCHs are transferred due to behaviour related issues. The other half are transferred due to ADL issues such as need for assistance with transfers, incontinence, and other needs.

ALS-SH providers indicated that the program lacked the ability to provide services to all who need it. With respect to human resource needs, providers noted the need for a strategy to address the skills gap in the ALS-SH workforce. Compounding the skills gap problem, providers reported difficulties in communicating with and securing a range of needed medical professional services and the need for case coordination.

The community and long-term care system in Ontario today is seriously under-resourced and at risk of not meeting the most basic health and safety needs of the most vulnerable citizens of our province.

This paper will identify some existing gaps that need to be filled in order to ensure that the health care system evolves as envisioned by the health care providers and the government.

² OANHSS (August 2009) "Assisted Living Services in Supportive Housing: On-line Survey and Key Informant Interview Results."

1.0 Key Government Health Care Priorities and the Implications for the Seniors' Care Continuum

One of the government's key priorities for the health care system is to reduce emergency room (ER) wait times. As noted in the MOHLTC Results-based Plan Briefing Book (2009-10), "Wait times cannot be solved by focusing on the hospital ER alone. Prompt emergency care can only be achieved by making improvements across the entire system." (p.2)

In recognizing that improvement in ER wait times can only be achieved by positive change in the health care system as a whole, the MOHLTC launched the Emergency Room – Alternative Levels of Care (ER/ALC) strategy.³ The strategies objectives are to: 1) reduce ER demand by providing appropriate community-based care, 2) build ER capacity and processes to improve the speed and effectiveness of the genuine emergencies, and 3) to more quickly discharge patients requiring alternative levels of care.

Of the estimated 2,894 ALC beds in the province 1,675 (58%) are filled by patients waiting for placement in LTC. The MOHLTC estimates that 20% to 30% of those ALC patients could be cared for in the community rather than in LTC;⁴ the extent to which this diversion would relieve pressure on the 25,000 plus provincial LTC waitlist is not known.

The basic logic of the ER/ALC initiative, from the perspective of LTC, is that the new programs and processes will place lower-need ALC patients back to the community with additional home care or assisted living supports thereby reducing ALC backlogs as well

³ The term "alternate level of care" (ALC) is defined by the MOHLTC as follows: "When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health, or Rehabilitation), the patient must be designated ALC at that time by the physician or her/his delegate."

⁴ MOHLTC, Assisted Living for High Risk Seniors Reducing Hospital ALC Pressures: Status Update to LHINs, October 8, 2009. p. 2.

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as curbing the flows directly into LTC. The end result, with respect to the new resident population will be higher overall acuity, or need. The effect of the ER/ALC strategy on LTC bed demand and waitlists remains to be seen. Because this strategy focuses on ensuring the right care in the right place, OANHSS members support it and wish to offer their full participation. The success of the senior's component of the ER/ALC initiative, then, hinges on the community and LTC sectors ability to provide the appropriate level of effective services.

The following sections will highlight what we see as critical issues that must be dealt with in order to ensure the success of the government's ER/ALC strategy and the continued evolution of effective and efficient community-based seniors' care in Ontario.

2.0 ER/ALC Success Factors: Integrity of the Seniors' Care Continuum

The service philosophy underlying the ER/ALC Strategy is consistent with that maintained by the not-for-profit community of seniors' care providers. Many not-for-profit LTCHs provide a continuum of care to their local communities that encompass the provision of seniors' services within the broader local community as well as on more localized 'campuses.' This continuum of care form of service organization has long focused on maintaining seniors' independence within their community. OANHSS members are understandably supportive of the ER/ALC strategy and particularly the Aging at Home element.

However, it is important that the government consider three areas of concern within the community and long term care system that present significant risks to the efficiency and effectiveness of the services provided to Ontario seniors and to the success of the ER/ALC strategy. The three areas are the quality and quantity of human resources, system change management ability, and capital maintenance and renewal.

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The availability of the right **quantity, quality and mix of human resources** that will enable the provision of the appropriate levels of direct care at all points along the continuum is a fundamental need and currently a major area of risk. The ER/ALC strategy recognizes that the cause of the ALC backlog has been inadequate community-based services and an over-reliance on a finite supply of LTC beds. Unless community and LTC services have the right quantity, quality and mix of appropriately trained personnel to provide care, seniors will continue to be marooned in ALC beds.

The government must understand that the community supports and long term care sectors that serve **seniors are not the place to look for cost savings**. Constraint options in long term care are basically restricted to staff layoffs. The sector operates with a very tight margin; in fact, most municipalities and charities voluntarily supplement provincial funding levels to achieve reasonable levels of care. These supplementary funding sources are also being pressed by the economy. Should restraint be imposed on seniors' community supports and long term care it will surely lead to substantial layoffs and concomitant reductions in the level of services, levels that are currently below standard.

The ER/ALC strategy is not the only major initiative affecting seniors' community supports and long term care. In addition to the ER/ALC strategy there is a wide-range of important and inter-related initiatives aimed at improving the health care system in general and services for seniors in particular. These initiatives all require some degree of resource investment on the part of service providers, any one of them could likely be managed by providers, but as the number of these initiatives increases it is becoming more and more a burden on both administrators and direct service providers. We will detail the range of initiatives and their corresponding resource demands below. Like the HR risks to the ER/ALC strategy, the relatively minor resource investments needed to **ensure the successful implementation of the Ministry's various system improvement initiatives** at the home level will be money well spent.

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How homes are modernized and maintained is a critical issue for residents of those homes and the people that work in them. The government has an ongoing renewal strategy that concerns itself with maintaining guidelines for the physical standards of long term care homes and providing funding when homes need to be refurbished or rebuilt to meet current standards, and when new homes need to be added to the overall provincial supply. The province's approach to LTC capital renewal is smart management. LTCHs also need to be able to **properly maintain their physical plants and plan and save for longer term capital replacement**. In the next section we will describe how this capacity is hampered in the current funding formula and how this may be fixed.

3.0 What Needs to be Done

3.1 LTC Workforce Capacity

The current LTC workforce, although highly dedicated, is struggling to provide care to the existing population. This is also true of community services personnel. If ALC patients, originally destined for LTC, are to be diverted to home or community care the appropriate **number** and **mix** of properly **trained** personnel need to be ready to serve them. Below we outline the needs in these three areas.

3.1.1 Quantity. As described above, LTCHs are dealing with higher and higher need residents, in particular with respect to activities of daily living (ADLs), mental health and behaviours and more complex medical needs. As of the most recently available Ministry staffing report data, the provincial average paid hours of direct care per resident day is 3.115 hours, this includes: 2.089 hours of PSW time, 0.762 hours of licensed nursing time, and 0.264 hours of program staff time per day per bed.⁵

⁵ People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care Homes. A Report of the Independent Review of Staffing and Care Standards for Long-Term Care Homes in Ontario. May 2008. "The Sharkey Report"

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The government recognized earlier in its mandate that this level of staffing was inadequate. In its FY2008-09 Budget the government committed to add 2,500 PSWs and 2,000 nurses. These staffing increases were in addition to a commitment to add funding for 1,200 RPNs late in 2007. This injection of resources would have increased the average paid hours of care by 0.405; bringing the average to 3.520 after all positions were hired. Unfortunately that hasn't happened. In FY2008-09, the MOHLTC allocated all of the 1,200 RPNs and 873 of the 2,500 PSWs promised. But in 2009-10 the MOHLTC allocated only 620 of the 2,000 nursing positions and none of the outstanding PSW funding.

The Sharkey Report, in May 2008, also recognized the need for increased staff and recommended an increase in staffing to 4.0 paid hours per resident per day by the end of 2011-12. At that point the government was already taking the steps noted above to address these pressures.

The current situation is that acuity levels continue to rise and relative level of care declines. We are nowhere near the recommended 4.0 hours of care and the government is holding back promised resources that would move us closer to achieving that recommended level of care.

OANHSS, along with other groups, join the Sharkey Report authors in calling for an increase to 4.0 paid hour of care per resident per day. However, this has to happen immediately, in FY2010-11. This is required by residents now; they cannot wait until 2012 or 2013, nor can the health care system – without these resources the seniors' element of the ER/ALC strategy will be hamstrung.

Recommendation 1: *In light of the increasing acuity levels of the LTC resident population and the associated care needs, OANHSS recommends that the government increase staffing levels to an average of 4.0 paid hours of care per resident day in 2010-11.*

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3.1.2 Skill Mix. Over the past few years there has been a concerning trend in the MOHLTC's approach to allocating human resource investments. As noted earlier, the Ministry has promised 2,000 new nursing FTEs, 1,200 RPN FTEs and 2,500 PSWs. As funding for these positions becomes available, the MOHLTC allocates them across homes on a proportionate basis, not based on demonstrated need. Some OANHSS homes have higher than average staffing levels due to added financial contributions made by their organization or municipality. We are aware of instances where the home requires the support of an occupational therapist or social worker as an example instead of an RN or PSW but that option is not available to them under existing funding rules for targeted positions. If these homes have already done the right thing by staffing up in these areas, the government should be providing incentives for such homes to hire other much needed positions.

Good human resource planning was recommended in the Sharkey Report. Recognizing the variation in service need and labour markets across regions and homes, the Sharkey Report recommended the introduction of annual staffing plans. These plans are developed individually within each home by a committee of labour, management and resident/family representatives. The planning approach is currently in the early implementation stage.

The Ministry is keenly interested in the efficient and effective use of human resources. OANHSS and its members share this interest. The insistence by the government to hire exactly 'X' number of each position, regardless of an individual home's actual need creates further inefficiencies and reporting requirements that draw attention and resources away from resident care. OANHSS supports the need for evidence-based human resource planning and allocations. One source of home level evidence that could contribute to LTC human resource planning is the data planned to be collected through the Sharkey staffing template process that has just recently completed pilot testing. We recommend that the Ministry compile the home level human resource data

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and associated intelligence to contribute to LTC human resource planning and allocation decision-making at the LHIN and provincial level.

Recommendation 2: *To facilitate evidence-based human resource planning and allocation decision-making at the LHIN and provincial levels, OANHSS recommends that the Ministry and LHINs use human resource data and associated intelligence collected at the home level through the Sharkey staffing template process.*

3.1.3 Training and Specialized Human Resources.

There is a very high prevalence of mental illness among residents in LTCHs. Recent studies report prevalence rates as high as 80%: in one such study, more than two-thirds of residents had some type of dementia, 10% suffered from affective disorders and 2.4% were diagnosed as having a psychiatric illness.⁶ Forty percent of the residents with dementia also suffered from psychiatric complications. Further, recent WSIB statistics are showing an increasing number of staff injuries due to violent responsive behaviours by residents.

Residents need appropriate care for their mental and behavioural issues, as well as, physical health. Since 1994, the obligation to address the needs of older adults with mental health issues has generated numerous discussion papers and strategy proposals by government in collaboration with experts. Over that time, the mental health status of LTC residents has declined and associated needs have increased. The July 2006 Coroner's inquest into two deaths at the Casa Verdes nursing home resulted in 85 recommendations aimed at preventing such situations in the future. Residents and staff need to feel and be safe, secure and protected in their homes. Appropriate staffing levels and training is required to ensure that it is.

⁶ Cited in National Guidelines for Seniors' Mental Health, Canadian Coalition for Seniors' Mental Health, May 2006.

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Recommendation 3:

The MOHLTC and appropriate stakeholder groups identify a system-wide human resource plan that is sensitive to local staffing needs required to properly and safely provide care to LTC residents with mental health and/or behavioural issues.

The cost of providing care to this growing subpopulation is not properly reflected in funds directed to specialized care and staff training. In fact, the resource demands stemming from residents with behaviour issues are not properly identified in the RAI:MDS Resource Allocation Grouping (RUG) method used by the MOHLTC in allocating funding based on resident needs. This systemic funding oversight needs to be corrected. In order to ensure that affected residents, other residents and staff are properly protected, focused investments in specialist human resources and staff training are required.

Recommendation 4:

The Ministry should commit to identifying the resource demands resulting from aggressive behaviours not accurately recognized and quantified in the current RUGs methodology. The Ministry should commit to completing its study, identify costs, and properly fund them before the end of the government's second quarter of the 2010-11 fiscal year.

Nurse-led outreach teams provide more care to patients from long-term care homes to avoid transfers to the emergency department and \$4.5 million for dedicated nurses to care for patients who arrive at emergency departments by ambulance to ease ambulance offload delays. However, outreach teams work out of emergency rooms and not in LTCHs. It is probable that this successful initiative would be even more successful if outreach teams attended to LTC patients at the LTCH as well as when residents have been transferred to the emergency room.

Recommendation 5:

The MOHLTC should enhance its nurse-led outreach teams by enabling the teams to be available within homes rather than just in hospital settings.

Investment in infection prevention and control is another area where there will be great returns for relatively low cost. Improved infection prevention and control will improve resident quality of life, improve resident safety, and decrease hospital admissions. The Provincial Infectious Diseases Advisory Committee (PIDAC) has recommended the MOHLTC increase funding for infection control personnel to hospitals and public health. However, LTC was not included in that recommendation.

We would hope that seniors living in LTCHs would be given the same protection through the provision of the equal resources to enhance infection prevention and control as is provided to the general public in hospitals. Further, we would suggest that new funding not be tied to the hiring of a certified infection control practitioner, as is the case for hospitals, because these professionals are in short supply. Rather, it would make more sense in the LTCH context to fund the augmentation of staff education and allocate more staff time for infection prevention and control. Homes could also continue to draw on the expertise within the infection control networks and public health to strengthen their programs.

Recommendation 6:

To ensure equal protection from infections for residents of LTCHs and hospital patients, it is recommended that the Ministry provide similar funding to LTCHs to ensure appropriate staff education and staff time is provided for effective infection control.

3.2 Human Resource Funding Equity

A point about funding equity needs to be included in any discussion of human resource funding to the not-for-profit sector. Not-for-profit homes have higher than average salary and benefit costs that many homes cover through their own contributions. Higher salary and benefit costs can be directly traced to pay equity costs which are controlled provincially. Municipalities, in particular, tend to experience higher arbitration settlement decisions due to their perceived ability to pay. The *Pay Equity Act* and certain of its provisions unintentionally created unfairness. The Act not only resulted in wage or cost differences between LTCHs but the provinces' funding provisions affected municipal homes differently as well. These, and other, unique cost drivers must be recognized by the province in allocating human resource funding.

3.3 System Change Management

The not-for-profit seniors' service sector recognizes the importance of the other key initiatives within the unprecedented overhaul of LTC. Myriad initiatives have and are being initiated that will contribute to the effectiveness and efficiency of the LTC system and ultimately benefit residents. A short list of such initiatives includes:

1. **The Ontario Healthcare Reporting Standards / Management Information Systems (OHRMIS).** This initiative is intended to switch financial reporting accounts to a common standard across all health care providers across the province. The common standard will result in common data definitions that will facilitate system-wide planning and analysis.
2. **The Resident Assessment Instrument Minimum Data Set (RAI:MDS)** is to be fully implemented across all 620+ LTCHs in the province. The RAI:MDS collects and assesses data on resident health status and needs. Data is collected quarterly on each resident in order to monitor for change and adjust care plans. The collected data is also used to assess the overall and relative 'acuity' level for each home. The data also contributes to health care system planning and is

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intended to be linked with the OHRIS/MIS data noted above to further strength health planning and research.

3. **Sharkey Staffing Plans.** The development of home level staff planning as described above.
4. **LHIN-LTC Agreement (LSAA).** Service agreements developed with the LHIN. The agreement specifies expectations and terms with respect to service provision.
5. **LAPS Planning Documents.** These planning documents specify levels or volumes of services to be provided in conjunction with the LSAA's.
6. **Compliance Transformation.** The Ministry is moving to a radically new approach to compliance monitoring. This initiative will require significant change in the way both the Ministry and homes look at compliance.
7. **Ontario Health Quality Council (OHQC).** In addition to developing performance indicators for public reporting and for the accountability recommendations from Sharkey, the OHQC is developing Quality Improvement Teams for LTCHs. Quality teams will develop and measure indicators and as well as identify quality improvement responses at the home level.
8. **New LTCHA Regulations.** The Ministry is nearing the completion of new regulations to guide the new *Long-Term Care Homes Act* (LTCHA). Many of the new regulations include new processes and in several cases increases in human resource requirements. Homes will have to be prepared to implement the new regulations; in some cases this will require significant new approaches to their work.

Our membership supports these system improvements and believes they will result in a more effective and efficient system. However, they come at a cost to homes. There are growing resource demands to properly plan and administer these initiatives at the home level. In implementing these and other initiatives, the Ministry cannot lose site of the fact that LTCHs are not large organizations. Initiatives such as those noted above typically require substantial involvement of the homes entire management team as well as some direct service personnel.

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Experience with the MIS and the MDS has been quite promising. The Ministry has been able to provide online and in person supports to homes in the implementation of these complex projects. This type of support is not only valuable to homes to ensure successful uptake, but it also helps to ensure that the time and energy of the Ministry is well spent. Most importantly the support team approach helps to ensure that the projects fulfill their objectives. This is good management.

Recommendation 7: *To mitigate resource demands on LTCHs resulting from the various system change initiatives mandated by the Ministry and to maximize the likelihood of success of those initiatives, we recommend that the Ministry uses a similar support model, with appropriate internal resourcing, that is employed with the MDS and the MIS projects.*

In commenting on draft regulations that will support the pending *Long Term Care Homes Act*, it has become clear that substantial costs will accrue to homes as a result of adherence to the new requirements. Specifically, draft regulations specify considerable skill training requirements and as increases in a number of staff positions. At this point, the full cost implications are unknown, we therefore suggest that the Ministry work with the two LTC associations to estimate these costs and that the Ministry ensure adequate funding is provided. Should the costs of new regulations not be recognized and provided, homes will be put in a position where they are unable to meet the requirements of the new regulations.

Recommendation 8: *The Ministry should work with the two LTC associations to estimate the cost impacts of the new LTCH regulations and the Ministry should provide the identified funding to ensure that homes are able to meet the regulatory requirements of the new legislation.*

3.4 Other Accommodation Envelope Pressures

3.4.1 Acuity-related Needs

The common thread running through this analysis has been the resource impacts of increasing acuity within LTCHs. The most obvious impact, as we have described, is that of the need for a larger supply of skilled human resources. But acuity-related cost pressures also arise for other items such as incontinence supplies, laundry, dietary supplements, assistive devices, resident monitoring technologies, etc. All of these expenditure items are funded through the Other Accommodation (OA) envelope, which does not receive acuity-related increases.

Further, these acuity-related pressures are compounded by other pressures in the OA envelope such as energy cost increases (averaging 6.0% between 2003 and 2008), large mortgage payments for some homes and high ongoing maintenance costs for older homes. When combined, these acuity-related costs attributed to the OA envelope add considerable pressure to homes' budgets.

Given that acuity is increasing and related changes affect all funding envelopes, it is imperative that all costs associated with acuity increases be recognized in the funding formula.

Funding of the Other Accommodation envelope has increased at an average rate of 1.9% since 2003; this is far below the actual increase in related costs. Last year (FY2009-10) the MOHLTC provided a "one-time" increase to Other Accommodation to offset some of the pressures in this envelope. That increase translated into a \$1.55 per diem increase.

Recommendation 9: *In order to recognize the increasing financial pressures resulting from acuity and inflationary growth and the associated impact on LTCH resident's quality of life, it is recommended that the Ministry fully annualize the one-time \$1.55 OA*

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increase from 2009-10 to base funding for LTCHs in 2010-11 and institute an ongoing inflationary factor to recognize the effect of cost inflation on providers.

3.4.2 Physical Plant Renewal

Apart from the basic input costs noted above, LTCHs also need to be able to properly maintain their capital plants and plan and save for longer term capital replacement. With respect to day to day maintenance, homes must ensure that lifts are properly maintained and that kitchen and HVAC systems keep up with ever changing regulations. This simply names a few of the day-to-day equipment maintenance pressures.

Although there may be room for 'surplus' funds within the OA envelope, when there is the not-for-profit sector reinvests OA surpluses to help offset some of the pressures related directly to resident care resulting from increasing acuity or capital necessities (maintenance and redevelopment).

Recommendation 10: *With respect to funding of ongoing capital maintenance costs it is recommended that the Ministry study options for ongoing funding of these costs.*

4.0 Conclusion

In this paper we have looked at needs and pressures within the community and long term care sectors serving seniors and shown how these pressures intersect with the quality, effectiveness and efficiency of seniors' care as well as how they will affect the success of the government's centre-piece of health care reform – the ER/ALC strategy.

We identify not just quantity, but also the quality and mix of human resources as the primary ingredient for both care and system improvement. And we provide specific

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recommendations on how to maximize the benefit of these ingredients. Many of the recommendations in this regard have been offered by the Sharkey Report and some have even been promised in past government budgets.

We also identify the need for the MOHLTC to properly facilitate system change management at the home level. We describe eight separate initiatives aimed at system improvement that the sector fully supports. However, all of these initiatives require resource input and process change within individual homes. Homes need help implementing these initiatives; the Ministry has provided such help for some of its projects and we recommend that that support continue to be provided whenever possible. The Ministry must ensure that the internal funds are available for this to happen. Again, it is a small investment that will go far to increase the odds of success of health system reform.

Finally, we point to the need to properly finance ongoing physical plant maintenance and renewal. A safe and secure physical environment contributes to resident well-being and it also ensures the longevity of the physical infrastructure.

For the system to improve, the changes and investments recommended here must be taken seriously and acted upon now. If they are not, the quality and quantity of seniors' care in the community and long term care homes will decline and the backlog of seniors languishing in ALC beds will continue, if not grow, and ER wait times will remain unacceptably high. OANHSS and its member organizations are anxious to avoid this negative outcome and contribute to the ongoing improvement of Ontario health care system to the benefit of Ontario seniors.

Summary of Recommendations

Recommendation 1:

In light of the increasing acuity levels of the LTC resident population and the associated care needs, OANHSS recommends that the government increase staffing levels to an average of 4.0 paid hours of care per resident day in 2010-11.

Recommendation 2:

To facilitate evidence-based human resource planning and allocation decision-making at the LHIN and provincial levels, OANHSS recommends that the Ministry and LHINs use human resource data and associated intelligence collected at the home level through the Sharkey staffing template process.

Recommendation 3:

The MOHLTC and appropriate stakeholder groups identify a system-wide human resource plan that is sensitive to local staffing needs required to properly and safely provide care to LTC residents with mental health and/or behavioural issues.

Recommendation 4:

The Ministry should commit to identifying the resource demands resulting from aggressive behaviours not accurately recognized and quantified in the current RUGs methodology. The Ministry should commit to completing its study, identify costs, and properly fund them before the end of the government's second quarter of the 2010-11 fiscal year.

Recommendation 5:

The MOHLTC should enhance its nurse-led outreach teams by enabling the teams to be available within homes rather than just in the hospital settings.

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Recommendation 6:

To ensure equal protection from infections for residents of LTCHs and hospital patients, it is recommended that the Ministry provide similar funding to LTCHs to ensure appropriate staff education and staff time is provided for effective infection control.

Recommendation 7:

To mitigate resource demands on LTCHs resulting from the various system change initiatives mandated by the Ministry and to maximize the likelihood of success of those initiatives, we recommend the Ministry uses a similar support model, with appropriate internal resourcing, that is employed with the MDS and the MIS projects.

Recommendation 8: *The Ministry should work with the two LTC associations to estimate the cost impacts of the new LTCH regulations and the Ministry should provide the identified funding to ensure that homes are able to meet the regulatory requirements of the new legislation.*

Recommendation 9:

In order to recognize the increasing financial pressures resulting from acuity and inflationary growth and the associated impact on LTCH residents' quality of life, it is recommended that the Ministry fully annualize the one-time \$1.55 OA increase from 2009-10 to base funding for LTCHs in 2010-11 and institute an ongoing inflationary factor to recognize the effect of cost inflation on providers.

Recommendation 10:

With respect to funding of ongoing capital maintenance costs it is recommended that the Ministry study options for ongoing funding of these costs.



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