OANHSS

The Need Is Now: Addressing Understaffing in Long Term Care

OANHSS Submission to the Ontario Standing Committee on Finance and Economic Affairs

Ontario Association of Non-Profit Homes and Services for Seniors

JANUARY 2015

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Funding Model and Other Funding Issues:

RECOMMENDATION 2:
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RECOMMENDATION 6:
That the Ministry of Health and Long-Term Care consolidate the RAI Coordinator, RPN, Physician On-call, and Laboratory Services funding and add a balancing increment that results in a per diem value that is equal to the highest aggregate per diem found for municipal, charitable or nursing homes. In addition, a mitigation strategy should be formulated to ensure homes with an aggregate per diem greater than the highest average per diem be provided with assistance to avoid hardship for residents.

RECOMMENDATION 7:
That the Ministry of Health and Long-Term Care budget for an increase in the Accreditation per diem from its current $0.33 per resident day (PRD) to $0.43.

RECOMMENDATION 8:
That the Ministry budget for a 2% increase to the OA envelope in order to maintain the physical well-being of the long term care homes as well as other OA pressures.

RECOMMENDATION 9:
That the Ministry of Health and Long-Term Care budget for a 5% increase to the raw food per diem to compensate for the variance between actual food costs and funding levels over the past five years.

Community Services Funding:

RECOMMENDATION 10:
That the Ministry of Health and Long-Term Care develop a funding framework to determine home and community care funding at the regional level and that framework development should include a review of the balance of funding between high risk seniors assisted living programming and non-high risk seniors programming .

1.0 Introduction

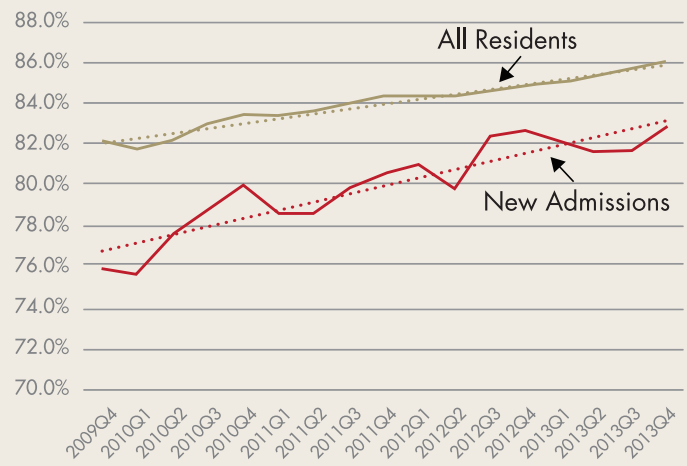
OANHSS is the provincial association representing not-for-profit providers of long term care, services and housing for seniors. Members include not-for-profit long term care homes (municipal, charitable and non-profit nursing homes) seniors' housing, supportive housing, and community service agencies. Member organizations serve over 36,000 long term care residents annually and operate over 8,000 seniors' housing units across the province.

This submission provides input from the non-profit long term care (LTC) sector's perspective on how the system can be improved through public investments and policy changes and enhancements; changes that the Ministry may wish to include in its 2015-16 budget planning process.

As of May 2014, the Ministry of Health and Long-Term Care (MOHLTC) reported approximately 20,700 seniors were awaiting placement in one of the 78,100 LTC long stay beds[1] in Ontario's 630 LTC homes. The occupancy rate in the province averages 98.9%. The overall average wait time to placement in a home is three months (89 days). Depending on priority, average wait times range from 64 days for crisis referrals (Priority 1) to 553 days for referrals to lower priority ethno-cultural or religion-specific homes (Priority 3B).

The people behind these numbers represent the most vulnerable of all societal groups; the frail elderly. Not all seniors need LTC and all stakeholders are working hard to enable seniors to remain in their own homes. The result of this policy direction, coupled with the demographics of aging, is that those with the greatest need are the ones being admitted to LTC homes. Accordingly, acuity in the LTC population is increasing as suggested in Figure 1, below.

FIGURE 1: MAPLe CATEGORY – HIGH TO VERY HIGH



This Figure shows the growth in MAPLe[2] scores for new admissions and existing residents of LTC homes since the last fiscal quarter of 2009-10 to the last fiscal quarter of 2013-14 with high to very high levels of impairment. New entrants into LTC are coming with much higher levels of impairment. In the 4th quarter of FY2009-10, 76% of new admissions had high to very high levels of impairment; 35% high and 41% very high. At the end of FY 2013-14, 83% of new admissions had high to very high levels of impairment, with most of the growth in the very high category representing 47% of new admissions and growing at 3.9% per annum while the high needs group, accounting for 36% of new admissions is growing at only 0.1% per annum. The impact on the overall resident population is clear. The proportion of high to very high levels

[1] These figures refer to long stay beds only, in May 2014 there were also 367 short stay, 499 interim, and 719 convalescent care beds within the system. Ministry of Health and Long Term Care. Long Term Care Home System Report, August 2014.

[2] The Method for Assigning Priority Levels (MAPLe score) is an assessment used to prioritize an individual's need for home care services and long term care placement. There are five groupings of impairment measured by the MAPLe scoring: Low, Mild, Moderate, High, and Very High. See Hirdes, Poss and Curtin-Telegdi, 2008.

of impairment is increasing in response to the higher acuity levels of new admissions, resulting in high to very high impairment levels growing from 82% to 86% over the period. The increase is driven by the very high category which grew from 52% to 56%, while the high category remained fairly constant at roughly 30%.

Although the LTC resident population suffers from a broad range of physical health issues, it is also afflicted with a broad range of mental health issues. Many of these issues affect a large and ever increasing number of residents. Table 1, below, shows the prevalence and rate of growth of some of the mental health issues for LTC home residents, the most common of which are dementias, which affect, on average, six out of 10 residents (60.4%); a number that is growing at an estimated 2.5% per annum. In terms of straight numbers this equates to just under 47,200 people across all homes, or, on average, 74 out of 119 people in each home. This is a huge and growing group of people in need.

Cognitive impairment, defined as a score of 4 or more on the Cognitive Performance Scale, and depression affect roughly 3 in 10 (27.9% and 32.5%, respectively). However, cognitive impairment is decreasing by an estimated 1.3% per annum.

Anxiety disorders are increasing at a rate of 8.8% and affect, on average, 8.9% of the resident population. Other less common psychiatric diagnoses, such as schizophrenia and bipolar disorder, 3.4% and 2.3% prevalence, respectively, are also growing at more modest rates of 1.4% and 2.4%, respectively. Although these more familiar psychiatric diagnoses are of lower prevalence, 39.2% of residents have a psychiatric diagnosis of one sort or another and that overall group is growing at 3.4% per annum.

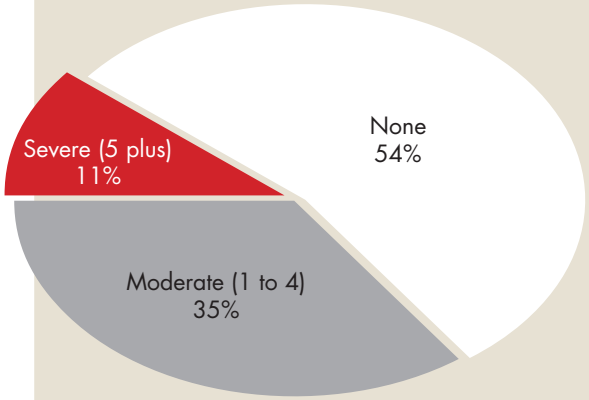
Aggressive behaviours can be a huge risk to resident safety and well-being, both those suffering from them and those around them, including LTC home staff and visitors. On average, 46% of residents engage in aggressive behaviours as measured by the Aggressive Behaviour Scale (ABS). (Perlman, C.M and Hirdes, J.P., 2008). As illustrated in Figure 2 (page 7), 35% of all residents have moderate levels of aggressive behaviour, scoring 1 to 4 on the ABS, and 11% are considered to show severe to very severe levels of aggressive behaviour with ABS scores of five or more.

TABLE 1: PREVALENCE AND GROWTH IN MENTAL HEALTH ISSUES

Impairment	Average Prevalence	Average Annual Rate of Growth
Dementia – all	60.4%	2.5%
Depression	32.5%	1.2%
Cognitive Impairment (Cognitive Performance Scale score 4 plus)	29.0%	**-1.3%**
Any Psychological Disorder	39.2%	3.4%
Anxiety Disorder	8.9%	8.8%
Schizophrenia	3.4%	1.4%
Bipolar	2.3%	2.4%

Source: CCRS, RAI-MDS Quarterly, January 1, 2010 to March 31, 2014.
All CCRS data courtesy of Dr. J. Poss, University of Waterloo

FIGURE 2: PREVALENCE OF MODERATE AND SEVERE AGGRESSIVE BEHAVIOURS



Aggressive Behaviour Scale (ABS) Ratings
Ontario LTC Resident Population
(Average Jan 1, 2010 to mar 31, 2013)

Providing care to this very high need population is a direct care workforce of approximately 48,315 FTE caregivers, or 3.44 paid hours per resident day (PHPRD).[3] As shown in Table 2, below, the largest group within that workforce is PSWs, accounting for 66% of the total direct care workers providing 2.252 hours PHPRD.

Nursing staff account for 27% of total care hours with RNs making up 10% (0.318 PHPRD) and RPNs account for 18% of the total providing 0.596 PHPRD. A small group of more specialized care providers constitute a very small portion of the direct care workforce. This group includes positions such as nurse practitioners, infection control specialists, clinical nurse specialists, etc. Another set of important program staff includes occupations such as social workers, activation workers, dieticians, physiotherapists and occupational therapists, etc. This group provides 0.265 PHPRD of care; 8.0% of total care hours.

A major thrust of our submission is that this level of staffing is inadequate to provide the level of care and quality of care that Ontario seniors need and deserve. It is our position that the increased staffing levels that we recommend will improve the level and quality of care and those improvements will be reflected in measureable outcomes in a number of areas including RQIs, HQO quality indicators, resident quality of life, as well as care provider job satisfaction and safety. This submission will also make recommendations for improved funding methods and related funding increases, all of which will contribute to improving the efficiency and effectiveness of the LTC system. Finally, we will make recommendations for funding equity within the area of assisted living / supportive housing aimed at prevention of physical and psychological decline in the low to moderate risk senior population living in the community.

TABLE 2: 2012 FTES BY NPC DIRECT CARE – ALL FUNDING SOURCES

Care Position	FTE	Paid Hours Per Resident Day (PHPRD)
Registered Nurse	4,461.6	0.3176
Registered Practical Nurse	8,367.6	0.5957
Personal Support Worker (& HCAs)	31,633.7	2.2520
Other NPC	130.4	0.0093
PSS	3,721.6	0.2649
Total	**48,314.9**	**3.4396**

Source: Ministry of Health and Long Term Care, 2013 LTCH Staffing Report

[3] We use "paid" rather than "worked" hours in order to more accurately reflect the full cost of employing the direct care workforce within the home. Paid hours include things like vacation time, statutory holidays, sick time, education leave, bereavement, etc. whereas worked hours do not. Worked hours is a more accurate measure of time spent directly providing care, but it underestimates the actual cost which is an important factor in the context of this budget submission.

2.0 Recommended Actions

2.1 Staffing Levels and Service Quality

In 2008, the MOHLTC commissioned a review of staffing and care standards and the relationship with improvement in the care of residents of LTC homes in Ontario. The review, carried out by Shirlee Sharkey, was entitled *People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care Homes*, commonly referred to as the "Sharkey Report." An important recommendation resulting from that report was that a target staffing level of 4.0 paid hours per resident day be set and met by the year 2012.

That target has not been met and as a result the associated level of care quality has not been possible.

More recently, the Long Term Care Task Force on Resident Care and Safety (2012) highlighted the need for the government to fully follow through on the Sharkey Report recommendations in order to improve the level of safety and care quality for seniors in LTC. In the words of the chair of that task force, Gail Donner, "There is no doubt that we don't have enough staff. It's past even talking about – you just have to go to a long term care facility to see that."[4]

The recommendation to fund 4.0 paid hours per resident day (PHPRD) is consistent with that of other LTC stakeholders, including unions, employers and consumer groups. The connection between improved staffing and improved quality is not just a call from stakeholders, but also a well-researched area in the academic literature.

"There is no doubt that we don't have enough staff;" says Gail Donner, who chaired Ontario's Long Term Care Task Force on Resident Care and Safety, "It's past even talking about – you just have to go to a long term care facility to see that."

A broad range of quality of care and quality of life improvements has been attributed to increased staffing levels in long term care homes; in Ontario (Harrington et al., 2012; Registered Nurses Association of Ontario, 2007, 2010; Ontario Nurses Association, 2014), other Canadian provinces (Canadian Union of Public Employees, 2009, McGregor et al., 2005), across the United States (Bowers, Esmond & Jacobson, 2000; Horn, Bergstrom & Smout, 2005; Hyer et al., 2009) and within jurisdictions across the European Union (Harrington et al., 2012).

[4] From: Healthy Debate. Editorial by Jeremy Petch, Mike Tierney & Greta Cummings. June 20, 2013 http://healthydebate.ca/2013/06/topic/quality/improving-quality-in-canadas-nursing-homes-requires-more-staff-more-training Last Accessed November 7, 2014.

The academic literature on staffing levels in long term care typically looks at the relationship between staffing levels and one or more physical health conditions or quality indicators. For example, Horn, Buerhaus, Bergstrom & Smout (2005) looked at a number of adverse conditions in relation to different levels of RN time providing direct care. They found increased RN time was associated with fewer pressure ulcers and urinary tract infections; less weight loss, ADL loss and catheterization; and, greater use of oral nutritional supplements. The study reported also that increased numbers of certified nurse assistants and licensed practical nurses were associated with a decrease in pressure ulcers.

Similarly, a 2009 study by the University of South Florida (Hyer et al, 2009) found lower than national average deficiencies related to actual resident harm or jeopardy, availability of ADL services, and pressure sores were associated with higher staffing levels.

Closer to home, the Ontario Nurses Association (ONA), in their submission to the LTC Task Force on Resident Care and Safety (ONA, 2012), noted a study (Dorr, et al, 2005) that found higher RN staffing levels (.50 to .67 RN hours per resident per day) were associated with lower pressure ulcer rates, urinary tract infections and hospitalizations. In another study, Horn et al (2005), found that residents receiving 30 to 40 minutes of RN direct care per day were 84 per cent less likely to develop a pressure ulcer and 42 per cent less likely to experience deterioration in their ability to perform activities of daily living.

Although the majority of staffing level studies focus primarily on physical health outcomes, a number of other studies look at the impact of staffing levels on residents' psychosocial well-being. These studies often focus on the role of PSWs and the critical importance of their relationship with residents (e.g. Armstrong, RNAO, Bowers, Esmond & Jacobson, 2000; Horn, Bergstrom & Smout, 2005). When PSWs, who provide the most personal of care, become less connected with individual residents, the negative impacts are significant for resident physical and psychological well-being. The risk of the loss of the PSW-resident relationship occurs when staffing levels are low and care provision becomes highly task oriented, somewhat like an assembly line approach. This approach is contrary to what we know to be best practice. The provision of relational care is best practice. With this approach it is the resident and not the task that is the focus of care. Relational care is also conducive to greater consistency of care which contributes to improved quality of life and quality of care. However, higher PSW to resident ratios are required to enable this more personal form of care.

The literature strongly supports the contention behind Sharkey's recommendations, and those of other stakeholders, that more staffing of a variety of types (i.e. RNs, RPNs, PSWs) is related to better quality of care, better resident outcomes and greater resident safety.

Through this submission, OANHSS is restating the need for the government to follow through with Sharkey's recommendations to increase funding to meet a target of 4.0 PHPRD.

Sharkey qualified her recommendation for a 4.0 hour target with another recommendation that called for the MOHLTC to leave the determination of the mix of care providers to individual homes and not to impose a province-wide mix. Her justification follows:

> Recent studies argue that staffing in LTC homes is a complex activity that requires consideration of a range of issues related not only to sufficient staffing capacity, but also to such factors as the mix of residents and their care needs, a home's philosophy of care, the service delivery model, the use of team approaches to care, and staff skill mix and experience. These studies strongly caution that simply establishing a staffing standard does not by itself address quality of life and care issues of LTC residents, and may in fact impede the consideration of other factors. (*People Caring for People*, May 2008, p.9)

We agree wholeheartedly with this qualifier and include it with our recommendation for provincial funding of a 4.0 PHPRD target. In the cost estimate below and throughout this paper, we use the identical measure of care used by Sharkey in her report and recommendation.

What will it take to get to 4.0 PHPRD?

As documented in Table 2, p. 6, there are just over 48,300 FTEs providing direct care to LTC residents in Ontario which translates into 3.4396 PHPRD[5]; 0.5604 hours short of the proposed target. Table 3, below, shows that a $13.84 increase to the NPC and PSS envelopes would be required to fill the care gap. Such an increase would require an annualized increase in spending of over $385M. Recognizing a) that it would be impossible to implement such an increase in one year, and, b) the current fiscal circumstances of the province, we recommend that the increase be implemented over a three-year period beginning in 2015-16.

Based on the academic literature it is anticipated that the increased staffing levels will result in improvement to the well-being of residents as reflected through improved HQO and CIHI Quality Indicators and through better RQI results, fewer complaints and fewer critical incidents.

RECOMMENDATION 1:
That the Ministry of Health and Long-Term Care set and fund over the next three fiscal years a system target of 4.0 paid hours of direct care per resident day (PHPRD).

TABLE 3: COST OF INCREASE TO 4.0 PAID HOURS OF DIRECT CARE

	Ministry and Non-Ministry Funded NPC & PSS
Total 2012 Direct Care Paid Hours Per Resident Day (PHPRD)	3.4396
4 Hours Shortfall	0.5604
Required % Hours Increase	16%
Total Direct Care Wage Cost PHPRD	$84.93
Gap Cost PHPRD	$13.84
Annualized Gap Cost	**$384,878,396**

Source: OANHSS calculations based on Ministry of Health and Long Term Care, 2013 LTCH Staffing Report (2012 data).

[5] When thinking about "hours per resident day" it is important to keep in mind that when we say 3.4396 hours PRD, we are referring to time over three 8 hour periods or shifts. On a shift basis, the 3.4396 translates to an average of 1.15 hours per shift. This is a relevant fact to keep in mind as one of the requirements for entry into long term care is the need for nursing care on a 24 hour basis, 7 days a week.

2.2 Funding Model and Other Funding Issues

We now turn to a set of proposals for a new funding model that will result in greater equity in the distribution of existing funding and improved flexibility for LTC providers. In this section, we offer specific suggestions that we feel will simplify the LTC funding model by increasing flexibility for homes, reducing unnecessary reporting requirements and maintaining resident-focused funding. Currently, there are effectively four level of care funding envelopes and, at last count, at least a dozen supplementary funding streams, all of which have comprehensive accountability criteria and reporting requirements. These funding sources require excessive resources to simply comply with the administrative requirements (reporting, tracking, etc.). This level of administration is inefficient and takes away from the core 'business' of long term care, that being the provision of high quality care to residents.

The overly defined criteria for the use of the various envelopes and funding streams also results in unused funds being returned to the MOHLTC each year as homes are reticent to risk overspending in each of the various funding sources. Fewer funding sources will simplify and reduce the risk of under-utilization of available resources. Greater flexibility in this regard will also lead to greater opportunity for innovation in the provision of care.

2.2.1 Reduce / Collapse the Current Funding Envelopes

A major component of the current LTC funding model is the envelope system, or Level-of-Care (LOC) funding. Four envelopes are commonly identified: Nursing and Personal Care (NPC), Program and Support Services (PSS), Raw Food (RF), and Other Accommodation (OA). A more flexible approach would be to collapse the two care related envelopes (NPC and PSS) and leave the accommodation related envelopes (OA and RF) as is.

Under this arrangement, program standards still must be met, and accountability would not be diminished. For example, the Accommodation, or non-acuity, envelope would remain a fixed per diem and the only envelope where profit or surplus may be generated. A portion (see section 2.2.2) of the Care, Service and Recoveries envelope would be adjusted province-wide based on annual changes in the provincial case mix index. Three significant benefits, however, would result from the financial management of a single care envelope. First, budgeting and reporting at the home level and reconciliation at the Ministry level would be streamlined due to the increased range of expenditure items that would exist within a new acuity-based care envelope. Second, homes would have greater ability to respond to developments and plan for the highest level of care with all care related expenditure items contained within the one acuity-based envelope. Third, the amount of annual under-spending solely driven by overly detailed financial management requirements would be reduced. The acuity-based care envelope would continue to be a flow-through envelope should under-spending occur.

This recommendation would extend the work already underway in the Ministry to identify and eliminate inflexibilities within the LTC funding model. The collapsing of funding envelopes would have no cost implications to the government.

RECOMMENDATION 2:

That the Ministry of Health and Long-Term Care collapse the current Nursing and Personal Care and Program and Support Services funding envelopes into a single, flow through, acuity-adjusted envelope and retain the Other Accommodation (OA) and Raw Food envelopes as a non-care, unadjusted envelope.

2.2.2 Recognize Fixed Costs

LTC homes are subject to considerable annual swings in funding levels resulting from changes to their Case Mix Index (CMI). These swings create considerable instability both financial and in terms of service continuity, as they often require layoffs that disrupt consistency of care. The ongoing risk of layoff also contributes to poor staff morale and diminished quality of the workplace more generally, all of which have a negative impact on the quality of care.

Further, the current approach to acuity adjustment of the entire care envelope does not factor in the reality of fixed costs. Within the care envelope, there are a number of fixed costs, including basic equipment and supplies, a core level of direct care staffing, the 24/7 RN requirement and the entire administrative structure supporting the delivery of care; including the Director of Care. These costs do not change with the changes in the CMI.

In order to improve stability within homes, both financial and care-related, OANHSS is recommending that the Ministry adopt a 'fixed-variable' approach to funding the care envelope. Such an approach would see a recognition of 50% of all care costs as fixed and 50% sensitive to acuity change and therefore reasonable for CMI adjustment. The need for a fixed-variable approach will be even more important given the recommended concentration of existing funds into the single, larger, care envelope. Therefore, we would see this and the previous recommendation as linked.

RECOMMENDATION 3:

That the Ministry of Health and Long-Term Care implement a fixed-variable (50% fixed and 50% variable) approach to the CMI adjustment of the proposed care envelope.

2.2.3 Measure Resident Acuity

Resident acuity has long been a focal point in LTC funding and it is now becoming even more important. The average acuity level of the LTC resident population is increasing as a result of demographic and policy change. Increased acuity levels create increased care requirements and resources. Although the current CMI serves as a measure of relative acuity levels within any given year, there is no recognized measure of year over year change in resident acuity at the provincial, LHIN or home level. The system requires a method of measuring change in the resident population acuity in order to gauge changes in resource requirements at the system and the home level. OANHSS urges the Ministry to make the development of a measure of year over year change in resident acuity a priority.

RECOMMENDATION 4:

That the Ministry of Health and Long-Term Care make the development of a measure of year over year change in LTC resident acuity a priority for 2015-16.

2.2.4 Merging Supplementary Funds

In section 2.2.1, we made recommendations that would simplify and improve the efficiency and effectiveness of the funding envelopes. In this section we recommend actions that will further simplify and improve the overall funding model by minimizing or eliminating supplementary funds.

In 2010, the Ministry allocated approximately $400M to 12 supplementary funds (or pots). These funds target a range of purposes that can be categorized into three areas: facility operating costs, targeted resident needs, and targeted human resource investments. This collection of funding streams has been developed over the past 20 plus years in isolation of the rest of the LTC funding components. The funding patchwork that has resulted is highly complex, in some cases of unknown benefit and purpose, and highly labour intensive to administer, access and report on. Further, the end result has been unbalanced and inequitable funding where some streams

are updated regularly and others are not. Such a consolidation and balancing of funding would remove inequities, simplify the funding process, eliminate a lot of administrative cost and put all homes on an equal footing. This recommended change can be taken independently of our recommendation to collapse the care envelopes.

The Ministry began the process of moving supplementary funds into the care envelope in 2012-13 with the High Intensity Needs Fund. However, it is our view that the supplementary pots should not be 'cherry picked' for consolidation into the envelopes as this approach will cause destabilization for segments of the provider population with each step. This approach, given the unequal shares of the supplementary funds across the historic provider types, will result in some sectors gaining if virtually all funds are not rolled into the envelope. This approach would sustain an untenable funding inequity.

In brief, OANHSS proposes the collapsing of all but two supplementary funds into the three envelopes recommended in Section 2.2.1. The Accreditation and Structural Compliance funds would be excluded from consolidation. We discuss these two streams in further detail on page 15.

The methodology for collapsing the funds and converting them to the envelopes will require a relatively small investment to bring all homes to the highest average total per diem currently provided. Also, a transition mitigation strategy will be required for homes that currently receive greater funding than the average combined supplementary funds.

Table 4 identifies the supplementary funds OANHSS recommends be consolidated into the non-acuity-based (accommodation) envelope per diem.[6] These supplementary funds were allocated a total of $217.84M in 2010. When these supplementary funds are disaggregated by home type (i.e. municipal, charitable or nursing home) we see significant differences in the overall and fund-specific shares on a per bed basis. The average total supplementary funding allocated to nursing homes is $9.20; charitable homes receive, on average $4.15; and, municipal homes receive an average total of $5.30.

Absorbing these funds directly into a per diem will perpetuate the inequitable distribution. OANHSS suggests a 'balancing increment' to the supplementary funds to shore up the funding inequities. Based on the 2010 data, the shoring-up increment would require an investment by the

TABLE 4: NON-ACUITY FUNDS[7]

Long-Term Care Homes Supplementary Pot Allocations (2010) – Per Resident Day

Not Acuity-based (NAB) Envelope	Municipal	Charitable	Nursing Home	Pot Total PRD
Equalization	2.28	2.44	1.41	1.71
High Wage Transition Funding	1.42	0.51	0.09	0.43
Pay Equity Funding	1.60	1.16	3.35	2.73
Municipal Tax Allowance Fund	-	0.03	4.35	2.94
Not Acuity-based Subtotal	5.30	4.15	9.20	7.80
Balancing Increment	3.89	5.05	-	1.39
Total Increase to NAB Envelope	9.20	9.20	9.20	9.20

[6] 2013 home level supplementary funding data will be required to identify the redistribution of funds into the new envelope structure and assess the requirements for a mitigation strategy. The 2010 data (financial and bed counts) used here is largely intended to illustrate the magnitude of the funding issues and the high level averages. Some funds, e.g. Pay Equity, may impact on care and non-care envelopes.

[7] Although we have characterized these funds as non-acuity resources, they are not all unrelated to care. Wage-related funds would cross the acuity – non-acuity divide and this fact would need to be considered in the reallocation to the three proposed envelopes.

Ministry of approximately $38.88M, representing a $1.39 increase to the overall aggregate average of $7.80. Table 4 provides details on the current distribution and the proposed balancing increment. The unknown risk at this point would be the cost of a mitigation strategy (e.g. red circling of homes receiving over $9.20 PRD in supplementary funding). For our analysis we have only sector and fund level data, for a more accurate analysis home level data will be required.

The consolidation of the numerous supplementary funds, each with its own administrative requirements and corresponding workload, into a reduced number of funding envelopes will result in a significant decrease in administrative burden for the Ministry as well as LTC homes.

RECOMMENDATION 5:

That the Ministry of Health and Long-Term Care consolidate the Equalization, High Wage Transition, Pay Equity and Municipal Tax Allowance funds and add a balancing increment that results in a per diem value that is equal to the highest aggregate per diem found for municipal, charitable or nursing homes. In addition, a mitigation strategy should be developed to ensure homes with an aggregate per diem greater than the highest average per diem be provided with assistance to avoid hardship for residents.

Table 5, below, details the funds OANHSS would recommend to be rolled into the acuity-based (care) envelope. Acuity-related supplementary funds provide for unique resident need costs. These funds were allocated a total of $113.56M in 2010, including two targeted human resource funds. We again recommend the same strategy for consolidating the funds, including a mitigation strategy, as proposed for the non-acuity funding. Consolidation of care-related supplementary funds would achieve the same benefits in terms of improved efficiency resulting from the elimination of administrative burden and improved equity in funding.

The shoring-up increment would require an investment by the Ministry of approximately $3.61M, representing a $0.13 increase to the overall aggregate average of $4.07. Again, the unknown risk at this point would be the cost of a mitigation strategy but given the nature of these pots, the variation would likely be much less, therefore reducing the expected cost of mitigation.

RECOMMENDATION 6:

That the Ministry of Health and Long-Term Care consolidate the RAI Coordinator, RPN, Physician On-call, and Laboratory Services funding and add a balancing increment that results in a per diem value that is equal to the highest aggregate per diem found for municipal, charitable or nursing homes. In addition, a mitigation strategy should be formulated to ensure homes with an aggregate per diem greater than the highest average per diem be provided with assistance to avoid hardship for residents.

TABLE 5: ACUITY-BASED FUNDS

Long-Term Care Homes Supplementary Pot Allocations (2010) – Per Resident Day

Acuity-based (AB)	Municipal	Charitable	Nursing Home	Pot Total PRD
RAI Coordinators	1.31	1.45	1.49	1.45
RPNs	2.02	2.13	2.14	2.11
Physician On-call Funding	0.28	0.31	0.31	0.31
Laboratory Services Funding	0.17	0.30	0.20	0.20
Acuity-based Subtotal	3.77	4.20	4.14	4.07
Balancing Increment	0.43	-	0.05	0.13
Total Increase to AB Envelope	4.20	4.20	4.20	4.20

Table 6 details, based on 2010 data, the expected $42.49M, or $1.52 per bed day, overall cost of consolidating the supplementary funds into their respective acuity and non-acuity envelopes.

The Remaining Funds: Accreditation and Structural Compliance

Accreditation provides an incentive for homes to become and remain accredited. This incentive contributes to an improved service quality in LTC and given its relevance to the provincial quality agenda, should remain separate and provided only to those homes that qualify. Over the period 1994 to 2013, the Ontario CPI has increased by 36% bringing the current value of the original $0.33 per diem to $0.23, an approximate $0.10 drop. Accordingly, we recommend that the accreditation per diem be increased from $0.33 to $0.43 to offset inflationary losses over the past two decades. The increase would also further incent those homes that have not yet taken this important step in quality improvement to do so.

RECOMMENDATION 7:

That the Ministry of Health and Long-Term Care budget for an increase in the Accreditation per diem from its current $0.33 PRD to $0.43.

Structural Compliance funding provides a per diem to homes that have completed some upgrades on their own in the past but still do not meet the 1999 design guidelines. All of these homes are candidates for the province's Redevelopment Program. We feel that this funding stream should remain until the redevelopment program is complete and then be allowed to sunset.

TABLE 6: EQUALIZING COSTS

Cost to Absorb Supplementary Pots into New Envelope Structure*

	Total Cost	Total Cost PRD
Not Acuity-Based Funding Increase	38,875,745	1.39
Acuity-Based Funding Increase	3,611,273	0.13
Total Funding Increase	42,487,018	1.52

*Cost before mitigation and based on 2010 data

2.2.5 Recognize Input Cost Pressures

Input costs in the Other Accommodation (OA) envelope cover a wide range of items including wages and benefits, utilities, building maintenance (including generators, elevators, roofs, etc) and equipment (including kitchen, laundry, building cleaning, etc.). We know wage rates have continued to rise by an average of 1.5% to 2.0% per annum, this despite the wage restraint policy and the absence of funding for wage increases. Minor capital costs increase in the absence of access to minor capital funding. And the pressure to meet the various health and safety requirements to ensure the safety and well-being of residents and staff continue to build. These financial pressures combine to outweigh available funding within the OA envelope resulting in lower maintenance levels and lower quality of the physical home, both inside and out. The sector has gotten by for some time with less than adequate increases to the OA envelope, averaging, less than 1.0% over the past two years. A catch-up increase is sorely needed to ensure homes are able to properly maintain themselves and plan and save for future redevelopment.

RECOMMENDATION 8:

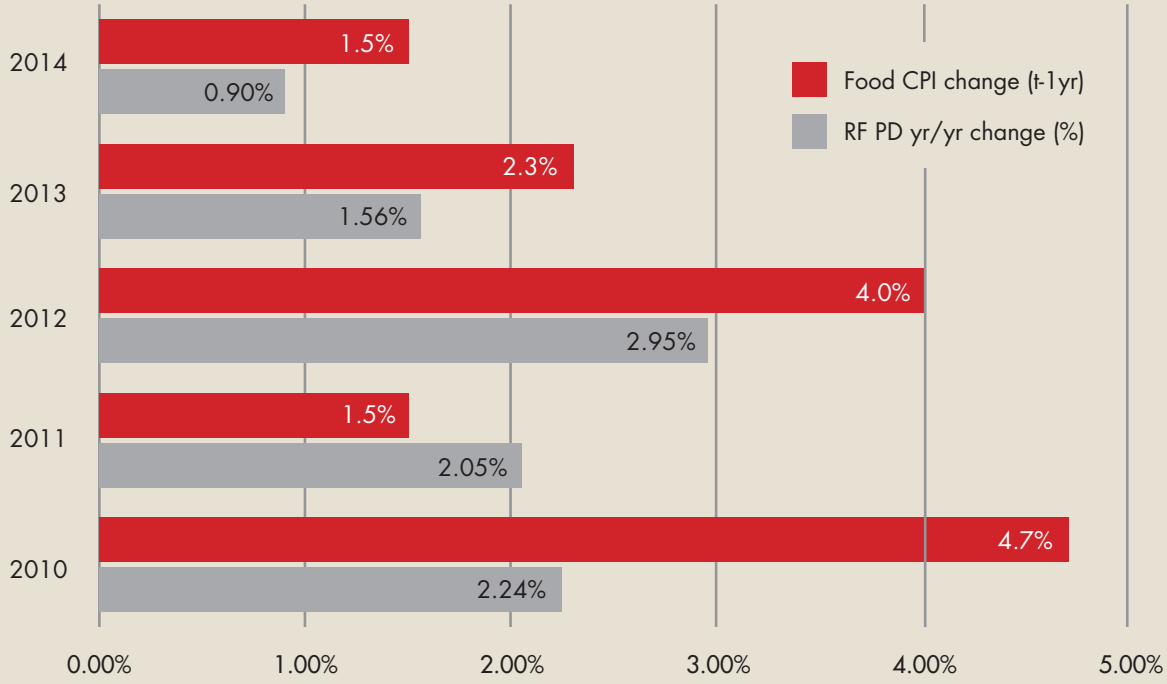
That the Ministry budget for a 2% increase to the OA envelope in order to maintain the physical well-being of the long term care homes as well as other OA pressures.

Food is another area of funding concern. For 2014 the Ministry provided an increase for raw food expenses of less than 1.0%. Figure 3 compares annual Ontario food CPI change and raw food funding increases from 2010 to the present. Over the period, Ontario food inflation has increased by a total of 11.5% where the cumulative increase for raw food funding has grown by 6.7%, leaving a 4.8% gap in funding vs cost. Clearly, catch-up funding is needed in this very important area of need. To that end, we recommend a 5.0% increase to the raw food per diem.

RECOMMENDATION 9:

That the Ministry of Health and Long-Term Care budget for a 5% increase to the raw food per diem to compensate for the variance between actual food costs and funding levels over the past five years.

FIGURE 3: ONTARIO FOOD CPI ANNUAL INCREASE AND RF PD INCREASES



2.3 Community Services Funding

Funding for home and community services varies significantly across LHINs causing inequities. As stated in a recent OACCAC white paper, *Making Way for Change* (undated), "the province committed to increase funding for home and community care by four per cent; the portion provided to CCACs varied from 27 per cent of the total community investment to 69 per cent." OANHSS echo's the OACCAC recommendation that the province needs to develop a "provincial funding framework to determine home and community care funding at the regional level to ensure more equitable, evidence-based and performance-driven funding decisions."

A related issue is the diminished and inconsistent funding for older "supportive housing" programming that provides a full range of services for seniors of varying levels of ability and acuity. These programs are not keeping pace with demand or costs. Newer "assisted living" programming that targets high risk seniors has been receiving increased funding over the past number of years but not the older programs. In order to ensure that seniors remain in the community, including those of lower to mid-level risk, more equitable funding for programming to prevent, or slow, deterioration to a higher level of need is required. In their *Advice on the 2014 Budget* (December, 2013) the OACCAC reported that service levels for low to moderate risk/need seniors has decreased from almost two thirds (62.3%) of all service recipients in FY2009-10 to 41.9% in FY2012-13 while the proportion of high risk/need service recipients (largely seniors) increased from 37.4% to 58.1% over the same period. OANHSS is in favour of ensuring supports to high risk seniors to enable them to stay in the comfort and security of their homes, but, we feel it is false economy to beggar preventative services to lower risk seniors.

RECOMMENDATION 10:

That the Ministry of Health and Long-Term Care develop a funding framework to determine home and community care funding at the regional level and that framework development should include a review of the balance of funding between high risk seniors assisted living programming and non-high risk seniors programming.

3.0 Conclusion

In this submission we have proposed recommendations that are evidence-informed, geared to improving quality of care and life for LTC residents and seniors in need of all levels of care in the community. We recognize that our staffing request is large given the fiscal constraints facing government, but we feel that Ontario seniors need and deserve this consideration. Again, the proposed staffing target is recommended for full implementation over a three year period. This is the same recommendation and timeframe recommended by Sharkey in 2008.

Our recommendations also identify an evolved LTC funding model that will simplify funding in this area while maintaining the resident focus. As a result, funds currently lost to administration and budgetary caution will be appropriately utilized to provide care rather than returned to the MOHLTC. We have also identified a number of funding pressures that need to be addressed.
If implemented, our recommendations will improve the safety and well-being of all LTC residents, seniors living in the community, health care provider organizations and their staff.

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