OANHSS

Proposals for the Ontario Budget

Fiscal Year 2012-13

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Ontario Association of Non-Profit Homes and Services for Seniors

Contents

1.0 Introduction

The population of Ontario is aging rapidly as the baby boom generation begins to reach age 65. The number of people 65 and over will gradually double over the next 25 years to 4.1 million. In 2036, nearly one quarter of all Ontarians will be 65 and over.[1] Although seniors are healthier today than in the past and will continue to be so, there will be more people requiring health care including long-term care in the years to come.

The report of the Drummond Commission has highlighted that reforms to health care in the province must be made to ensure cost-efficient and higher-quality services to Ontarians.[2] More specifically, the recent *Caring for our Aging Population* report by Dr. David Walker has called for a long term strategy that delivers dignified, appropriate care and intervention for those unable to live independently but not requiring hospital-based care.[3]

This submission provides analysis and recommendations as to how the Ontario government, as part of its 2012-13 budget, can ensure that current and future Ontarians are provided with high-quality and cost-efficient long-term care.

The Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) is the provincial association representing not-for-profit providers of long-term care, services and housing for seniors. Members include municipal and charitable long-term care homes, non-profit nursing homes, seniors' housing projects and community service agencies. Member organizations operate over 27,500 long-term care beds and over 5,000 seniors' housing units in hundreds of communities across the province. Many members of the association provide a continuum of care for individuals and families in their communities.

The aim of our recommendations is to maximize the value of resources allocated to long-term care services for residents of long-term care homes through measures that increase flexibility, ensure adequate planning for future needs, safeguard accountability, and enhance the integration of services.

[1] Ontario Ministry of Finance. 2011. *Ontario Population Projections Update, 2010-2036*. Available at: http://www.fin.gov.on.ca/en/economy/demographics/projections/#s2
[2] Drummond Commission Report, p. 202.
[3] Walker report, p. 28

2.0 Context

There is general agreement that strategic decision-making is critical to ensure that health care services in Ontario remain responsive to the needs of the population and the fiscal capacity of the government. Furthermore, there is agreement that overall health care expenditures will be constrained and that, as noted by the Drummond Commission, a more efficient health care system will need to deliver more value for money spent.

Long-term care is a key component of health care in the province, with services provided by long-term care homes accounting for $3.77 billion, or 7.7% of annual total health expenditures.[4] The long-term care system is very large, with more than 630 homes across the province caring for more than 78,000 residents with 19,000 individuals waiting for a bed at any given time. The average long-term care home has 125 beds and range of staff including nurses, dieticians, personal support workers and many others. Long-term care is indispensable for those, usually older individuals (the average age of residents is 82), whose health and related needs cannot be met in the family home or in a hospital. For many families, long-term care guarantees that older loved ones receive the professional care they require in a safe and reassuring environment.

Long-term care is provided in homes that are either operated on a for-profit basis, or in homes that are charitable, not-for-profit and municipal. Charitable, not-for-profit and municipal homes account for approximately 46% of all long-term care beds, and most are represented by OANHSS. Both for-profit and not-for-profit homes are funded in the same manner by the Ontario Ministry of Health and Long-Term Care.

Three strategic policy directions arise from both the Drummond Commission and the Walker report in regard to long-term care.

1. The central role of both short-term and long-term planning, including capacity planning, to ensure that the current and future needs of the population are addressed.[5]

2. Funding arrangements that encourage equitable, cost-efficient and high-quality long-term care.[6]

3. The need for long-term care homes to be provided with appropriate human and interventional resources to expand their capability to meet the care of patients with more complex conditions.[7]

[4] In 2010-11 total health expenditures were $44.77 billion. See Drummond, p. 147, chart 5.1.
[5] See Walker, recommendation R24, page 24. See also Drummond, recommendation 5-76, pages 192-93.
[6] See Drummond, page 202.
[7] See Walker, recommendation R23, page 24. See also Drummond, recommendation 5-76, pages 192-93.

These broad policy directions form the basis of the analysis and recommendations that follow in this submission. The recommendations are designed to implement the advice offered by the Drummond Commission and Walker report, and to ensure that individuals and families across Ontario have access to high quality long-term care provided by charitable, not-for-profit and municipal homes.

3.0 Policy Direction: Short Term and Long Term Planning

3.1 Multi-Year Budgeting

The ability to budget for several years is critical for long-term care homes. The 2011-12 Ontario Budget committed the government to a 3% increase in the Nursing and Personal Care envelope, and also in the Program and Support Services envelope in each year from 2011-12 to 2013-14. That promise has allowed homes to plan on a multi-year basis and injected some much needed stability in the process that homes use to provide the best possible care for residents. Multi-year planning by homes is something that OANHSS has promoted for many years. That 3% increase will equate to approximately $81 million in 2012-13.

The long-term care sector faces continued cost pressures. For example, wages account for about 75% of total costs for long-term care homes. The Public Service Compensation Restraint Policy has managed to hold union wage settlement increases to about 2%, on average, over the past two years. Nonetheless, the government has not funded these wage increases. In addition to wage inflation, other government policy changes increased the cost of providing long-term care and the growing acuity of people coming to LTC has been increasing adding to the overall cost burden. All of these pressures combined far exceed the promised 3%.

The new *Long-Term Care Homes Act* and its regulations have created legal requirements for significant capital investments such as new industrial grade back-up generators, new door and communications systems. The estimated average cost of the required generator alone is approximately $200,000, or up to about $150 million for all homes. Recently, the Ministry announced a one-time allocation of $20.3 million to assist with minor capital costs related to resident safety.

The Act also mandated increases in staffing, specifically, increases in dietician, nutrition manager and food service worker time. OANHSS estimated the cost impact of these and other human resource increases to be $43 million. The Ministry responded to these regulation-related costs through the last Provincial Budget with an allocation of approximately $15.5 million for the human resource cost impacts of the regulations. Although appreciated, the Ministry contributions are not adequate for the regulatory requirements that long-term care providers must meet.

As noted previously in this submission, there is a broad transformation in regard to the characteristics of long-term care residents as increased efforts to maintain people in the community (such as Home First) take effect. Homes are bearing these financial pressures and managing within their budgets, notwithstanding that they cannot run deficits. The government's provision of a multi-year commitment has facilitated their ability to properly plan and that is what homes have done. The ability to plan into the medium term improves system stability. We trust the government recognizes the seriousness with which providers have taken their 2011-12 multi-year commitment and follow-through on it accordingly.

Recommendation 1: *That the government follow through with the 3% level-of-care increase committed in the 2011-12 Provincial Budget and reconfirm the same for 2013-14 to bring stability to and provider confidence in the long-term care funding system. This would provide funding stability for long-term care homes.*

3.2 Basic Co-Payments

Residents of LTC homes pay a monthly co-payment which is set by government; normally every year and usually based on CPP/OAS increases. Residents who cannot afford the co-payment are provided with rate reductions. Co-payment revenue flow helps the government offset some of the non-health related costs of the LTC program. Last year the Ministry of Health and Long-Term Care chose not to have an increase in co-payment rates, but instead provided homes with a funding increase in the amount of $0.82 per resident per day; $0.69 allocated to Other Accommodation and $0.13 allocated to Raw Food. However, unlike co-payment increases that are permanent, the Ministry provided this payment in lieu of a co-payment rate increase as a one-time payment – meaning it will be taken back in the coming fiscal year unless it is 'annualized', or made permanent. If the government does not annualize their payment in lieu of last year's co-payment, then the funding level to LTC homes will be going down, further aggravating the pressures facing LTC providers. We therefore need government to ensure that this funding is annualized and that a reasonable co-payment rate increase this year be levied in order to ensure homes do not fall further behind in funding these areas.

Recommendation 2: *That the government fully annualize the $0.82 per resident per day payment in lieu of last year's co-payment increase and that the government resume its practice of applying basic annual co-payment increases consistent with increases to the federal CPP and OAS programs for 2012-13.*

3.3 Major Redevelopment and Minor Capital Maintenance

3.3.1 Capital Redevelopment

Approximately 35,000 of the provinces 79,000 beds were due to begin redevelopment in order to meet current design standards last year. Although the government initiated a funding program and implemented a call for proposals, the uptake of the program was low. The stated reason for the low uptake was that the funding provisions were not adequate to properly finance redevelopment. The sector estimated a $4.35 shortfall in funding. An increasing number of homes needing redevelopment are experiencing difficulty filling their beds despite the existence of a 19,000 person waitlist. The government needs to recognize the true cost of this needed redevelopment and provide adequate funding to ensure the upgrade of these homes.

Recommendation 3: *That the government recognize the true cost of redevelopment of this large segment of LTC homes by increasing their proposed per diem funding by $4.35 to ensure that residents have equal access to safe and comfortable homes across the province.*

3.3.2 Minor Capital Funding

Long-term care homes need to properly maintain capital plants, and to plan and save for longer term capital investment. With respect to day-to-day maintenance, homes must ensure that lifts and elevators are properly maintained and that kitchen and HVAC systems meet regulations. Also, most homes are either currently paying for a recent redevelopment or planning for one in the near future. New regulations recently enacted as part of the *Long-Term Care Homes Act* require a number of capital investments on the part of homes, such as enhanced emergency back-up electricity generators, doors and security systems often in response to the more complex needs of residents.

An example of the minor capital expenditures of home are the regulations introduced as part of *Act* that mandate many homes to upgrade back-up electrical generators. Many homes that have very recently redeveloped and invested in back-up electrical generators now find that they are required to replace those with more costly generators. The new regulations also mandate that new back-up electrical generators be installed in homes that will soon be rebuilt or demolished. The cost of the capital investments for replacing existing equipment make the regulations considerably farther reaching and more comprehensive than originally envisioned.

Although the Ministry of Health and Long-Term Care has recently provided an additional $20.3M to assist with capital costs associated with the new regulations, that amount will not be adequate to fund for emergency electricity generators alone. Based on an OANHSS member survey, it is estimated

that the cost of meeting new regulations will be $150 million for all not-for-profit providers of long-term care, with individual home cost estimates ranging from $75,000 to $500,000 and averaging around $200,000.

The Ministry of Health and Long-Term Care has created a fund – the Health Infrastructure Renewal Fund – for hospitals with capital needs under $1 million. A similar fund would be suitable for long-term care homes. Alternatively, the Ministry and Local Health Integration Networks could permit long-term care homes to access the existing Health Infrastructure Renewal Fund.

Recommendation 4: *That the Ministry of Health and Long-Term Care develop a minor capital fund for long-term care homes, for ongoing capital maintenance costs and capital requirements under new regulations, or include such costs in a consolidation of supplementary funds. This would allow homes to undertake the necessary capital projects to provide the required level of care.*

Recommendation 5: *That the Ministry of Health and Long-Term Care grandfather existing long-term care homes from new emergency back-up electrical generator regulations, until such time as these homes are redeveloped or rebuilt. This would allow provincial funds to be spent as efficiently and effectively as possible.*

3.4 System Capacity Planning

The Walker report recommended a review of current capital planning models and making certain that the geographic location of long-term care homes corresponds to the identified need.[8] The Drummond Commission reinforced the Walker recommendations and called for the development of a comprehensive 20-year plan for health care in Ontario.[9] OANHSS recognizes that there is a need for the provincial government to undertake capacity planning to inform decision-making about the type and number of beds and services that Ontarians will need in the near and longer-term.

The planning process will need to take into account that there are 19,000 individuals waiting for a long-term care bed at any given time. Notwithstanding efforts to provide for home and community care, the number of people in need of long-term care might well increase in the years to come given longer life spans and an aging population. In any case, as noted by Walker and Drummond, capacity planning undertaken now is essential.

Lastly, as part of any planning and reform process, it is critical to ensure that the existing providers of long-term care have the stability in funding to provide efficient and effective service to residents. In

[8] See Walker, p. 24 and recommendation R24b.
[9] See Drummond, p. 174, especially recommendation 5-1.

this context, the commitment by the government to a 3% increase in the Nursing and Personal Care, and the Program and Support Services envelopes for 2012-13 and 2013-14 are particularly critical.

Recommendation 6: *That the Ministry of Health and Long-Term Care with the involvement of stakeholders undertake a capacity planning process to determine future needs for services for the elderly across the continuum of care (i.e. acute care, home care, assisted living and long-term care). This would ensure that decisions are evidence-based and made in an inclusive and participatory manner.*

4.0 Policy Direction: Funding Arrangements

Funding for long-term care homes currently derives from three main sources. These are: 1) level of care funds from the Ministry of Health and Long-Term Care; 2) special purpose supplementary funds from the Ministry of Health and Long-Term Care; and 3) co-payments made by individuals at levels determined by the government. In each of these sources of funding, there are policy reforms that can be undertaken to increase equity and efficiency.

4.1 Increasing Flexibility within Envelope Funding

There are four funding envelopes within the level of care funds received by long-term care homes: 1) Nursing and Personal Care, 2) Program Supports and Services, 3) Raw Food, and 4) Other Accommodation. Unused funds in the first three envelopes must be returned to the Ministry of Health and Long-Term Care through an annual reconciliation process. Unused funds from the Other Accommodation envelope are not required to be returned to the government and may be retained by the provider. With the exception of Other Accommodation funds, money may not be moved from one envelope to another.

Having four separate envelopes necessitates each home establishing separate budget management systems for each envelope. To avoid over-spending in one envelope, homes must monitor each envelope separately and the Ministry audits each envelope separately on an annual basis. Managers of homes tend to under-spend, to avoid deficits in any given envelope, which results in surpluses that upon reconciliation will be returned to the Ministry. The result is that spending decisions by a home are sometimes made not in the interests of ensuring effective and efficient care, but rather to meet accounting regulations.

A more flexible budgeting process would maximize the benefits of money from the Ministry by allowing the reallocation of funds between the envelopes related to care: Nursing and Personal Care; Program Supports and Services; and Raw Food. Spending pressures due to unforeseen developments in the course of a year in a particular aspect of care could be relieved by a transfer of funds from one envelope to the other.

Incontinence care funding is an example of the problematic aspects of the current financial reporting requirements. Homes are required not only to report expenditures related to incontinence care, but must report it in two separate funding envelopes. Expenditure for incontinence supplies up to $1.20 per resident per day must be reported in the Nursing and Personal Care envelope and any amount in excess of $1.20 limit must be reported in the Other Accommodation. There is no apparent reason as to why reporting at this level of detail is of value to the Ministry or assists homes in providing care to long-term care residents.

A more flexible and comprehensive approach to providing funds is to create only two spending envelopes: 1) Accommodation; and 2) Care, Services, and Recoveries.[10] Under such an arrangement, program standards still must be met, and accountability would not be diminished. However, three significant benefits would arise. First, budgeting and reporting at the home level and reconciliation at the Ministry level would be streamlined. Second, homes would have greater ability to respond to developments and plan for the highest level of care. Third, the amount of annual under-spending solely driven by overly detailed financial management requirements would be reduced. Such a rationalization of funding requirements would have no cost implications to the government.

Recommendation 7: *That the Ministry of Health and Long-Term Care review the current envelope funding arrangement with the objective of increasing the flexibility to transfer of funds between the care and program envelopes or reduce the number of envelopes. Such greater flexibility would allow homes to most effectively allocate funds to meeting the needs of residents.*

Recommendation 8: *That the Ministry of Health and Long-Term Care review the detailed reporting requirements for long-term care homes with an aim to streamlining these. This would streamline budgeting and reporting for both the Ministry and for long-term care homes.*

[10] The Accommodation envelope would remain a fixed per diem and the only envelope where profit or surplus may be generated. A portion of the Care, Service and Recoveries envelope would be adjusted province-wide based on annual changes in the provincial case mix index.

4.2 Supplementary Funds

The second source of funding for long-term care homes are special purpose moneys provided in addition to the level of care funds discussed above. In 2010 the Ministry of Health and Long-Term Care allocated approximately $397 million of long-term care spending to 12 supplementary funds. These funds target three costs in incurred by homes that are not adequately funded by the level of care funding particularly: 1) facility operating costs, 2) direct care supplements, and 2) human resource investments.

Operating supplements accounted for roughly two thirds of all supplementary funding allocated in 2010 ($251.3M). The second group of supplementary funds provide for unique resident need costs such as extraordinary treatments for residents with acute or intensive needs. These funds total about $45.9M. The third set of funds target human resource expenditures, such as the hiring of specific staff, and amounted to almost $100 million in 2010. See appendix A for additional details on these supplementary funds.

Table 1: Operating Supplements by Home Type, Per Resident Day*

Long-Term Care Homes Supplementary Pot Allocations (2010) - Per Resident Day				
Operating Supplements	**Municipal**	**Charitable**	**Nursing Home**	**Total PRD**
Accreditation	0.22	0.20	0.30	0.27
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
Debt Service	-	0.03	-	0.00
Structural Compliance	1.21	1.38	0.76	0.92
Municipal Tax Allowance Fund	-	0.03	4.35	2.94
Total	6.73	5.76	10.25	9.00

* "Per Resident Day" provides a common denominator (number of residents days) that allows for comparison of financial inputs across homes of different sizes. $1.00 per resident day is equivalent to approximately $28.8 million in provincial funding.

These 12 funds have not received regular review which has resulted in some funds remaining at levels that account for actual costs incurred by homes and others not. The result is that major funding imbalances have arisen. For instance, the Municipal Tax Allowance Fund, which recognizes the variability of property taxes paid by homes across the province, grew from $42 million in 2004, to $67 million 2005, and to $82 million in 2010. In contrast, other funds have not grown at all, for example the High Wage Transition Fund has stayed at just below $12 million over the same period. Table 1 above provides an overview of these supplementary funds by home type.

The absence of regular review and coordination of these funds has created a significant inequality across the long-term home sector. Generally nursing homes have benefited disproportionately from supplementary funding relative to municipal and charitable homes. This is especially true with respect to facility operating subsidies. In 2010, nursing homes, predominantly in the for-profit sector, received $188 million in operating subsidizes compared to $36 million for municipal homes and $15 million for charitable homes.

In order to address inequities that have arisen and to streamline the flow of funds, the Ministry of Health and Long-Term Care has two options. First, to fully review the range of current cost drivers of long-term care homes to create an index of legitimate cost drivers such as high wages resulting from arbitrated settlements, property taxes, location of homes (rural or urban), structural compliance, etc. That index could be used to allocate the current supplementary funding across all homes.

The second option is to dissolve all the supplementary funds that have arisen over time, which were often meant to exist for a limited period of time, and incorporate all supplementary pots into existing level of care funding envelopes. This would simplify and streamline funding arrangements and provide the opportunity to increase the equity in the allocation of funds.

For any new approach to supplementary funds, an ongoing process for monitoring, updating, and coordinating long-term care funding should be developed and adopted to ensure homes are fairly resourced to provide similar levels of care to residents.

Either approach has the potential to dramatically increase flexibility, reduce administrative burden on homes, Local Health Integration Networks and the Ministry, and improve funding equity across subsectors. A common benefit of all of these outcomes would be improved flow of resources to residents.

Recommendation 9: *That the Ministry of Health and Long-Term Care undertake a comprehensive review of existing supplementary funding programs with the goal of reducing the number of separate pots devoted to operational costs. This would ensure that funds are allocated equitably to current priorities and result in a less administratively intense process for both the government and providers.*

4.3 Preferred Accommodation Rates

Preferred accommodation rates, which are paid by residents over and above basic co-payment rates for semi-private and private accommodation, have not been changed since their introduction in 1993. On the other hand, the basic co-payment required from all residents has increased regularly and is currently $53.23 per day or $1,619.08 per month.[11]

The Ministry of Health and Long-Term Care has been investigating the viability of an increase to the current preferred accommodation rates for semi-private and private accommodations ($8.00 and $18.00 respectively on top of the basic co-payment) and OANHSS has been encouraging the Ministry to continue this work and assign it a high priority.[12]

An increase in preferred accommodation rates can be justified on both economic and equity grounds. From an equity perspective, the stagnation of preferred accommodation rates benefits those residents who are able to afford the premium charged, presumably those who have higher income levels, than those who cannot afford the premium and pay only the basic co-payment rate. However, because the basic co-payment has risen almost annually, those paying the basic rate are paying more in relation to those paying the preferred accommodation rates, which have not risen.

From the economic perspective, many homes, over time, have significantly upgraded their physical infrastructure and level of service. The enhanced infrastructure and level of service has not been matched with an increased contribution on the part of a subset of the resident population. If the $8.00 charged for semi-private accommodation was adjusted for inflation since 1993 it would equal $11.36 today, while the $18.00 charged in 1993 private accommodation would amount to $25.50.

In order to ensure that preferred accommodation costs accurately reflect housing costs, the Ministry of Health and Long-Term Care may wish to link these annually to the annual rent increase guidelines as set by the Ministry of Municipal Affairs and Housing or the Consumer Price Index. Such annual and transparent increases in preferred accommodation rates would assist current and potential residents, families, as well as operators of long-term care homes in their planning and decision-making.

Since homes are able to retain 100% of preferred accommodation revenue, an increase in such revenue will help with overhead costs incurred by homes, such as utilities and WSIB which rise each year. The revenue would also assist homes in meeting the capital costs for redevelopment discussed in Section 3.2.1. Lastly, some homes will redeploy the increased revenue to the level of care envelopes.

[11] Financial assistance is available from the Ministry of Health and Long-Term Care to those residents who are in basic accommodation and are unable to pay the co-payment. Financial assistance is not available for semi-private or private rooms.

[12] The semi-private room rate is $61.23 per day (the basic rate of $53.23 plus $8.00) which is $1,862.41 per month. The private room rate is $71.23 (the basic rate plus a maximum of $18.00) which is $2,166.58 per month.

Recommendation 10: *That the Ministry of Health and Long-Term care increase the preferred accommodation rates for semi-private and private accommodation in long-term care, and establish a mechanism to review these rates annually. The outcome would be greater equity across residents in different types of accommodation, as well as greater resources for homes to meet expenses.*

5.0 Policy Direction: Human and Interventional Resources

The composition of residents of long-term care homes is changing for two major reasons. First, individuals are living longer requiring long-term care at older ages than in the past and sometimes with multifaceted needs. Second, policy is encouraging more individuals to remain in the community and receive home care services where required. This shift results in higher average acuity levels within long-term care homes as lighter care needs are now able to be met in the community or at home. The result is that the care required by those in long-term care homes is more demanding, complex and intensive than ever before.

5.1 Changing Characteristics of Residents

A recent study estimated that 45% of residents in long-term care in Canada "exhibited one or more behavioural symptoms, which included verbal or physical abuse, social inappropriateness, and resistance to care and wandering."[13] In Ontario this translates into about 35,100 residents who exhibit this kind of behaviour.

Often such behaviour can present a risk to residents, staff, visitors and others, as well as interfere with the efficient provision of care. For example, a resident that is actively resisting assistance in toileting, bathing or dining will require more time on the part of staff to properly provide that care; it might take two personal support workers to help someone to get dressed in the morning rather than one or none at all.

Long-term care funding is based on assessed resident needs using an assessment tool: the Resident Assessment Instrument-Minimum Data Set. This tool is sophisticated but it fails to properly identify residents in the situation described above, or others who, for example, may have complex needs

[13] Canadian Institute for Health Information. *"Caring for Nursing Home Residents with Behavioural Symptoms: Information to Support a Quality Response."* March, 2008, p. 1

related to demented or cognitive impairment and could exhibit aggressive behaviour.[14] Therefore the added resources, e.g. providing care with two personal support workers rather than one, are not identified and consequently not funded. Estimates of the additional resource requirements for behaviour-related care not captured by the current assessment tool range from about $115 million, $3.98 per resident per day, to $179 million per year, $6.20 per resident per day.

The Ministry of Health and Long-Term Care has been reviewing this issue with OANHSS and other stakeholders but the progress has been too slow. The Ministry and the LHINs are in the process of implementing a $40 million ($1.38 per resident per day) Behavioural Supports Ontario program which is expected to contribute to improved care for residents with behavioural issues. However, this program alone will not offset the underfunding of day-to-day of behaviour-related care provision. The commitment from the government for a 3% increase in the Nursing and Personal Care, and Program and Support Services envelopes in each year for 2012-13 and 2013-14 will also help to meet these costs, but will not be sufficient.

The potential impact of not finding a solution to this issue extends beyond dollars and cents, the longer homes are left under-resourced to deal with behavioural issues, the greater the risk to the safety and well-being of other residents, care staff and visitors. Given the government fiscal circumstances OANHSS does not expect a full response to this need at this time, but it is critical that something be done to ensure the welfare of residents and staff. Government has to move beyond studying this issue and begin to adjust funding levels in order to begin to meet this important need.

Recommendation 11: *That the Ministry of Health and Long-Term Care finish its review of behaviour-related resource shortfalls and begin to increase funding levels at an appropriate rate.*

5.2 Incontinence Supplies

Incontinence supplies are but one example of how changes in the characteristics of residents impacts on long-term care providers. In 2010, over 70% of long-term care residents experienced some bladder incontinence and over 50% experienced some bowel incontinence.[15] This represents a 2.5% and 3.0% increase, respectively, from figures just two years earlier.[16] Improper treatment of

[14] The verdict of the Coroner's Jury of the Casa Verde Nursing Home in 2005 recommended that sufficient weight is given to actual and potential aggressive behaviours to enable adequate staffing, time and resources for long-term care facilities. The Coroner's report noted that there have been 14 homicides committed at nursing and long-term care homes between 1998 and 2005 and indicated that reports of aggression are increasingly common.

[15] Continuing Care Reporting System, 2010–2011, Canadian Institute for Health Information.

[16] OANHSS calculations based on Continuing Care Reporting System, 2008–2009, Canadian Institute for Health Information.

incontinence results in, among other health problems, an increased incidence of bed sores and infections. Incontinence will become more prevalent in concert with the increasing acuity of the long-term care resident population.

The Ministry of Health and Long-Term Care effectively caps expenditure on incontinence supplies in the Nursing and Personal Care envelope at $1.20 per resident per day. This amount is insufficient, as, according to our most recent data, not-for-profit homes spent $1.53 per person per day on such supplies, which is $3.1 million more than allocated by the Ministry.[17] Consequently, homes are regularly transferring money from the Other Accommodation envelope to ensure that incontinence supplies meet the needs of residents.

Recommendation 12: *That the Ministry of Health and Long-Term Care eliminate the $1.20 cap on incontinence products in the Nursing and Personal Care envelope and no longer require that such expenditures be tracked individually. Should the elimination of the cap not be feasible to implement in the short-term, it is recommended that the cap be increased to $2.00. This would result in a lessening of administrative requirements and ensure that Ministry funding reflects the actual needs of residents and expenditures by homes.*

5.3 Public Service Compensation Restraint Act

The *Public Service Compensation Restraint Act (PSCRA)*, which was introduced as part of the 2010 Provincial Budget, froze the salaries of non-unionized employees within the public service as well as government transfer payment organizations that receive more than $1 million in government funding. Municipal homes and the for-profit homes are not covered by the legislation. Charitable and not-for-profit nursing homes, and within that group only those homes that are not unionized and the small group of non-union management employees within unionized homes, are directly affected by the *Act*. Collectively this is a relatively small group of homes and staff that are affected but they are affected dramatically by the inequity of the partial reach of the *Act*.

This inequity within the LTC sector is particularly unfair because every long-term care home regardless of whether it is a for-profit nursing home, municipal home, charitable home or not-for-profit nursing home, is funded in exactly the same way by the Ministry. Unionized and for-profit homes are exempted, however, they are covered by the PSCR policy; a separate mechanism that is not as effective as the PSCRA. As noted earlier homes covered by the policy had their wage increases dampened, but not frozen. The consequence has been that homes in the not-for-profit

[17] The OAHHSS data is for 2009.

long-term care homes sector, and in particular those that are not unionized are losing their ability to attract and retain staff in an already extremely competitive labour market.

The PSCRA expires March 31, 2012, and should it be renewed for another 2 year period, the small homes noted above will be legislated to a **four year wage freeze** placing them in an untenable position in the LTC labour market and resulting in a decline in their ability to provide care for their residents.

Recommendation 13*: That the government exempts the LTC homes currently affected by the PSCR Act and rely on the moral suasion of the PSCR policy for all LTC homes. This approach will ensure that all providers are treated equally and are able to operate on a level playing field.*

6.0 Summary of Recommendations

This submission analyzes the key developments in long-term care, especially as they impact on resident care and well-being. The recommendations support the strategic directions of the government and seek to rationalize and streamline existing processes, and respond to changes in the characteristics of long-term care residents. As importantly, the recommendations reinforce that both short-term and long-term planning, including capacity planning, are critical to ensure efficient and high-quality long-term care for the people of Ontario.

Recommendation 1: That the government follow through with the 3% level-of-care increase committed in the 2011-12 Provincial Budget and reconfirm the same for 2013-14 to bring stability to and provider confidence in the long-term care funding system. This would provide funding stability for long-term care homes.

Recommendation 2: That the government fully annualize the $0.82 per resident per day payment in lieu of last year's co-payment increase and that the government resume its practice of applying basic annual co-payment increases consistent with increases to the federal CPP and OAS programs for 2012-13.

Recommendation 3: That the government recognize the true cost of redevelopment of this large segment of LTC homes by increasing their proposed per diem funding by $4.35 to ensure that residents have equal access to safe and comfortable homes across the province.

Recommendation 4: That the Ministry of Health and Long-Term Care develop a minor capital fund for long-term care homes, for ongoing capital maintenance costs and capital requirements under new regulations, or include such costs in a consolidation of supplementary funds. This would allow homes to undertake the necessary capital projects to provide the required level of care.

Recommendation 5: That the Ministry of Health and Long-Term Care grandfather existing long-term care homes from new emergency back-up electrical generator regulations, until such time as these homes are redeveloped or rebuilt. This would allow provincial funds to be spent as efficiently and effectively as possible.

Recommendation 6: That the Ministry of Health and Long-Term Care with the involvement of stakeholders undertake a capacity planning process to determine future needs for services for the elderly across the continuum of care (i.e. acute care, home care, assisted living and long-term care). This would ensure that decisions are evidence-based and made in an inclusive and participatory manner.

Recommendation 7: That the Ministry of Health and Long-Term Care review the current envelope funding arrangement with the objective of increasing the flexibility to transfer of funds between the care and program envelopes or reduce the number of envelopes. Such greater flexibility would allow homes to most effectively allocate funds to meeting the needs of residents.

Recommendation 8: That the Ministry of Health and Long-Term Care review the detailed reporting requirements for long-term care homes with an aim to streamlining these. This would streamline budgeting and reporting for both the Ministry and for long-term care homes.

Recommendation 9: That the Ministry of Health and Long-Term Care undertake a comprehensive review of existing supplementary funding programs with the goal of reducing the number of separate pots devoted to operational costs. This would ensure that funds are allocated equitably to current priorities and result in a less administratively intense process for both the government and providers.

Recommendation 10: That the Ministry of Health and Long-Term care increase the preferred accommodation rates for semi-private and private accommodation in long-term care, and establish a mechanism to review these rates annually. The outcome would be greater equity across residents in different types of accommodation, as well as greater resources for homes to meet expenses.

Recommendation 11: That the Ministry of Health and Long-Term Care finish its review of behaviour-related resource shortfalls and begin to increase funding levels at an appropriate rate.

Recommendation 12: That the Ministry of Health and Long-Term Care eliminate the $1.20 cap on incontinence products in the Nursing and Personal Care envelope and no longer require that such expenditures be tracked individually. Should the elimination of the cap not be feasible to implement in the short-term, it is recommended that the cap be increased to $2.00. This would result in a lessening of administrative requirements and ensure that Ministry funding reflects the actual needs of residents and expenditures by homes.

Recommendation 13: That the government exempts the LTC homes currently affected by the PSCR Act and rely on the moral suasion of the PSCR policy for all LTC homes. This approach will ensure that all providers are treated equally and are able to operate on a level playing field.

Appendix A:

Long-Term Care Supplementary Fund Allocations

by Home Type, Per Resident Day, for 2010

Long-Term Care Homes Supplementary Pot Allocations (2010) - Per Resident Day				
Operating Supplements	**Municipal**	**Charitable**	**Nursing Home**	**Total PRD**
Accreditation	0.22	0.20	0.30	0.27
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
Debt Service	-	0.03	-	0.00
Structural Compliance	1.21	1.38	0.76	0.92
Municipal Tax Allowance Fund	-	0.03	4.35	2.94
Subtotal	6.73	5.76	10.25	9.00
Direct Care Supplements	**Municipal**	**Charitable**	**Nursing Home**	**Total PRD**
Physician On-call Funding	0.28	0.31	0.31	0.31
Laboratory Services Funding	0.17	0.30	0.20	0.20
High Intensity Needs Fund	1.02	1.43	1.13	1.14
Subtotal	1.47	2.04	1.64	1.64
Targeted HR Funding	**Municipal**	**Charitable**	**Nursing Home**	**Total PRD**
RAI Coordinators	1.31	1.45	1.49	1.45
RPNs	2.02	2.13	2.14	2.11
Subtotal	3.33	3.59	3.63	3.56
Grand Total	8.20	7.81	11.89	10.65

Note: “Per Resident Day” provides a common denominator (number of residents days) that allows for comparison of financial inputs across homes of different sizes. $1.00 per resident day is equivalent to approximately $28.8 million in provincial funding.